# Dr. Lisa Scholder, LP

901 Twelve Oaks Center Drive #926E
Wayzata, MN 55391
(612) 300-2440

**Authorization for Release of Confidential Information**

I, _____, (date of birth) _____, authorize Lisa Scholder, LP to exchange information with the following individuals/organizations:

**Name/Agency**_____

Address _____

Phone (_____) _____ Fax (_____) _____

This release is for the purpose of:

_____

This release is valid for one year from the date below or until_____

This release may be revoked by client at any time for any reason by initialing here_____
And providing revocation date_____

_____ _____

**Client Signature** **Date**