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Authorization for Release of Information

I do hereby authorize the exchange of my medical and treatment information between:

And

This authorization is valid for one year, and can be revoked by written notification to all parties involved.

Client/patient name: _____

Address: _____

Phone: _____

Date of Birth: _____ Social Security # : _____

Client/patient signature: _____

Date: _____

Counselor signature: _____

Date: _____