RELEASE OF INFORMATION

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Date:_____

Patient Name:_____

D.O.B.:_____

I consent to the release of medical/mental health information about myself or about my child (if a parent in behalf of a minor child) to/from the above named L.P.C. This information may include diagnoses, prescribed medications, test results and/or clinical impressions.

Signed_____

Date_____

This release of information document is valid for a period of
90 Days from the date of patient signature.