

Consent to Release Confidential Information

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I give permission for:

Name of therapist _____

Address _____

Phone number _____

To release confidential information to:

Name of therapist _____

Address _____

Phone number _____

This release will be valid for 6 months from the signature date. This information is being released for the following reason:

Patient name (printed)

Patient signature (if minor, parent signature)

Address _____

Phone number _____

Date signed _____