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AUTHORIZATION TO REQUEST OR RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____ Date of Birth: _____

Name of Parent/Guardian (if minor): _____

I hereby authorize Jill L. Schram, Ph.D. to request/release/exchange information from/to/with the following individual, provider, or institution. (Please specify direction of information exchange.)

Individual, Provider, or Institution

Address

Telephone _____ Fax _____

Specific Information to be Requested/Disclosed : _____

Purpose of disclosure: _____

This authorization shall expire on: _____

Signature of Client, or Parent/Guardian Date Signature of Witness

