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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I ­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the Clare Albright, Psy.D. to release to and exchange with:

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the following information pertaining to myself:

all case information – diagnosis, treatment, progress notes

for the purpose of coordinating treatment efforts.

This consent will automatically expire one (1) year after the date of my signature as it appears below.

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

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Signature of Client Date

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Signature of Witness Date