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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

Patient name: _____ Date of birth: _____

I, _____, give my permission to
(patient/legal guardian)

(physician/clinician/agency/institution)

to exchange relevant medical, education/academic and psychological records regarding:

(myself/minor)

with _____
(physician/clinician/agency)

at _____
(address)

I understand that this information will be held in confidence.

Signature: _____
(patient/legal guardian)

Date: _____

This is effective for one year after date of signing unless stipulated below:

Effective Date: _____ End Date: _____