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AUTHORIZATION FOR RELEASE OF INFORMATION

I hereby authorize the release of and exchange of all pertinent medical, psychological, and educational information concerning (client) ______________________________________ between ______________________________ and Cathleen D. Stafford for use in assessment, consultation, and/or psychotherapy. This authorization shall be valid until: ____. I agree that a photocopy of this authorization shall be valid as the original, and that I may revoke this release at any time. I have received a copy of this authorization.

Signed ____ Date ________________________

(Client, parent, or guardian)