Family & Child Development

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RELEASE OF INFORMATION

I hereby authorize _____

To release ( ) all, or the following designated part (s): _____

_____

_____

of my medical and/or psychotherapy records, under the name of

_____

These records may be released to: _____

_____

SIGNED: _____ DATE: _____
Signature of patient or in the case of a minor child, the person authorized to sign.

_____
Printed name of patient, or person authorized to sign

WITNESS: _____ DATE: _____

_____
Printed name of witness