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RELEASE OF INFORMATION

RE: _____

Date: _____

To: _____

I hereby authorize you to release to and to receive information from:

Any information including the diagnosis and records of any treatment or examination to me during the period from _____ to _____

I understand this authorization shall remain valid from the date of my signature below and for 12 months thereafter or ending on: _____. I have been informed that I may revoke this authorization by written or oral communication to the Robert Cohen, Ph.D., P.A. I certify that this form has been fully explained to me and that I understand its contents.

Signature

Responsible Adult if minor

Witness

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