Windham Counseling Services

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AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Client(s) ______________________________ Birth Date ______________________

This authorizes ____

____

To release to ____

____

The following information:

____
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____ This authorization shall be in effect for one year from the date signed below.

____ This authorization shall be in effect only until ___________________.

Client signature _______________________________

Client signature _______________________________

Therapist signature _____________________________ Date _______________