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AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____(client first and last name) authorize the exchange of information between Adrie-Anne Gamble, MA, CCC, CPC and

_____(name of physician)

_____(physician contact info.)

for the purpose of collaborating a treatment plan for the above mutual client/patient..

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____

Client Signature Date