ASSOCIATES IN PSYCHOLOGICAL SERVICES, P.A.

Re: _____

PERMISSION TO RELEASE OR OBTAIN INFORMATION

I (we) hereby authorize and request _____

_____

to release or obtain confidential professional information, including personal,

psychological, psychiatric, and medical records and opinions, resulting from contacts with

them, to/from:

_____

_____

Signature:_____ Date:_____

Signature:_____ Date:_____

Witness:_____ Date:_____

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