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Release of Information Consent Form

I, ___________________________, give Dr. Sarah Allen permission to release and receive information regarding my treatment, with the following:

Name:_____________________________

Address & contact details: ____

____

I do not consent to release the following information:

____

____

I understand that I can withdraw my consent at any time.

Signature:____

Client signature (Client's Parent/Guardian if under 18 years old)

Date: ___/___/___