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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

Patient Name:_____ Date of Birth:_____

Dr. Marianne O'Leary hereby has my authorization to release psychological and other clinical information regarding the patient named above, for the following purpose:

_____

Signature:_____ Date:_____

Name of Signer (please print):_____

Relationship to Patient:_____

This authorization applies only to the institutions/individuals named below:

Name: _____

Telephone: _____

Address: _____

Name: _____

Telephone: _____

Address: _____