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AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize the release of all information relevant to the treatment of
________________________________ , Date of birth: _______________________.

This authorization applies to an exchange of information between Michael I. Vickers, PhD and ________________________. Such exchange may occur on one or more occasions, as is needed to complete the intended consultation successfully.

I understand that this authorization is valid until either treatment is ended or I submit in writting a request to discontinue this information exchange.

_________________________________ _____________________
Signed (self) Date

_________________________________ _____________________
Signed (guardian) Date