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# EXCHANGE OF INFORMATION FORM

I hereby authorize the exchange/release of pertinent information (psychological, medical, and/or school record) regarding my or my child's treatment between/to Sarah Patz, Ph.D. and/from the following professional or agency:

_____
Name of professional or agency

_____
Address

_____
Phone number

_____
Client's name

_____
Client’s signature

_____
Parent/Guardian signature (if needed)

_____
Relationship to child (if needed)

_____
Date