Release of Information Form

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I _____,
Client/Parent/Guardian (please circle)

Authorize James J. Sanders, LMFT, to release/obtain information to/from:

_____

_____

_____

This information is for the sole purpose of continuity of professional care for

_____.

I understand I can revoke this authorization at any time with
written notice to James J. Sanders, LMFT

Signature:_____ Date_____

Signature:_____Date_____