

Renew

PSYCHOTHERAPY

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CONSENT FOR RELEASE/EXCHANGE OF INFORMATION AND RECORDS

I hereby authorize _____ of Renew Psychotherapy to
_____ Release To _____ Release From

Doctor, professional, or agency

Address

Phone

Any and all information from records pertaining to:

Name(s) of Patient

Address

Phone

Date of Birth

Name of Patient (Print)

Signature of Patient

Signature of Parent/Guardian

Date