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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

RE: _____

Date of Birth: _____

This is to authorize _____ and Dr. Andrea

Leiman to disclose and release to one another any information, including

psychological and psychiatric records, pertinent to the above-captioned

individual's treatment and progress. This information is considered instrumental to

the ongoing evaluation and treatment of the patient.

Any cancellation or modification of this authorization must be in writing to both

parties.

Date _____ Signature _____

(Patient, Parent or Legal Guardian)

(Relationship to Patient)