William Valdivia-Mairesse, Psy.D.

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**Consent To Release Authorization**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, the undersigned, give permission to William Valdivia-Mairesse Psy.D. to release and provide to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Name)

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The following information (check all that apply) :

\_\_\_ my attendance in therapy

\_\_\_ my diagnosis

\_\_\_ my treatment plan

\_\_\_ information relevant to coordinating care

\_\_\_ when treatment is terminated and why

\_\_\_ other (please explain in detail)

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I understand that that this release is valid until the end of treatment. I further understand that I may revoke this authorization at any time in writing. In consideration of this consent, I hereby release the above parties from any legal liability resulting from the release of this information.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Date