Authorization to Receive/Release Medical Information

Client Name: _____

Address:_____

_____

I hereby authorize the release of medical information relating to the above-named person between Judy Phillips, Ph.D. and the following professionals:

_____

_____

_____

Signed: _____

Date: _____

☐ Parent

☐ Guardian

Judy Phillips, Ph.D.
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(619) 220-2525 (ph)