

## CONSENT FOR RELEASE OF INFORMATION

To: \_\_\_\_\_ Re: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I hereby give my consent for the release of information with Dr. Judith A. Peters, including any and all information regarding the history, observations, therapy and treatment for.

Client Print Signature: \_\_\_\_\_

Client Signature: \_\_\_\_\_

Date of Consent: \_\_\_\_\_

Client Phone No.: \_\_\_\_\_

Judith A. Peters, Ph.D.



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