**Fly Family Therapy and Neurotherapy**



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FLY FAMILY THERAPY

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
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| Patient’s Name: | | | | | | |  | | | | Date of Birth: | | |  | | | | | | |
| Parent Name (if under 18): | | | | | | |  | | | | Social Security #: | | | |  | | | | | |
| I request and authorize | | | | | | | | | |  | | | | | | | | | | to |
| release information regarding medical, psychological, and mental health treatment information of the patient named above to: | | | | | | | | | | | | | | | | | | | | |
|  | | Name: | | | |  | | | | | | | | | | | | | | |
|  | | Address: | | | | | | |  | | | | | | | | | | | |
|  | | City: | | |  | | | | | | | State: |  | | | Zip Code: | | |  | |
| This request and authorization applies to: | | | | | | | | | | | | | | | | | | | | |
| 🞎 Healthcare information relating to the following treatment, condition, or dates: | | | | | | | | | | | | | | | | |  | | | |
|  |  | | | | | | | | | | | | | | | | | | | |
| 🞎 All healthcare information | | | | | | | | | | | | | | | | | | | | |
| 🞎 Other: | | |  | | | | | | | | | | | | | | | | | |
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|  | | | |  | | | | | | | | | | | | | | | | |
| Patient (or Parent, if under 18) Signature: | | | | | | | |  | | | | | Date Signed: | | | | |  | | |
|  | | | | | | | | | | | | | | | | | | | | |
| THIS AUTHORIZATION EXPIRES SIX MONTHS AFTER IT IS SIGNED. | | | | | | | | | | | | | | | | | | | | |