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Consent to Release/ Exchange Information

PATIENT NAME ____ DOB ______________

SPOUSE'S NAME _______________________________________ DOB ______________

We,____authorize

Mimi Leung-Pang, LMFT

to release the specific information as follows:

1. to disclose to / exchange with ____
(Professional)

2. Length of time the information will be kept before being destroyed or disposed of:

____

3. I understand that I may revoke this authorization at any time.

____ __________________
Signature Date

____ __________________
Signature Date