

TRANSFORMATIVE PSYCHOTHERAPY, L.L.C.
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Authorization For Release of Information

I authorize _____ Jeannine Vegh, M.A., I.M.F.T. _____ to release

(state specific nature of information to be disclosed)

about _____ to

(Receiving person and institution/agency/organization)

(Address)

For the purpose of:

This consent is valid until: _____

I understand that I may revoke this consent at any time and that the above-named person authorized to receive this information has the right to inspect and copy the information to be disclosed.

It has been explained to me that if I refuse to consent to the release of information, the following are the consequences (specify, if any):

(Signature)

(Witness)

(Date)

(Date)