



Robert D. Wells Ph.D. & Associates
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RELEASE OF INFORMATION

Patient's Name: _____ Date of Birth: _____

I, the undersigned, consent to release and authorize Robert D. Wells Ph.D. and Associates and the following agencies and/or individuals to exchange medical, social, psychological and educational information regarding the above named person:

Name of Agency or Individual	Address

I do not want the following information to be exchanged:

This release of information will remain in effect until: _____

Patient's Signature

Date

Parent or Guardian's Signature (if Patient is a minor)

Date