**THE WASHINGTON CENTER FOR COGNITIVE THERAPY**

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 **AUTHORIZATION FOR RELEASE OF INFORMATION**

TO: (Provider’s name)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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I hereby authorize you and Vincent Greenwood, Ph.D. to exchange with each other any

And all information, both oral and written, concerning my history, condition, and treatment

For the purpose of coordinating and improving my treatment. I authorize that this information exchange may continue for two years commencing from the date of my signature below. I understand that I may rescind this authorization at any time through a written statement signed by myself.

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

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Client Name (Printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_