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EXCHANGE OF INFORMATION FORM

I hereby authorize the exchange/release of pertinent information (psychological, medical, and/or school record) regarding my or my child's treatment between/to Daniel Hettleman, Ph.D. and/from the following professional or agency:

Name of professional or agency

Address and/or best contact information

Phone number

Client's name

Client's signature

Parent/Guardian signature (if needed)

Relationship to child (if needed)

Date