

# ESSENTIAL STRIDES COUNSELING

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## RELEASE OF INFORMATION FORM

I, \_\_\_\_\_, authorize Dr. Michelle Wedig to disclose/release information for the purpose of my treatment to/from:

Name	Relationship	Address	Phone
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I understand this authorization expires on \_\_\_\_\_ (or 1 year from today) and can be revoked by me at any time.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date