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Signed Permission for release on transmittal of information:

I hereby give permission to Grace C. Riddell, L.C.S.W.. L.I.C.S.W. to obtain pertinent clinical information.

*Name of Patient:*____ *Birth Date:*____________________

Address of patient: ____

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*Name of psychotherapist:*____

Address psychotherapist ____

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Signature of patient: ____ *Date:* ____________________