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Authorization for Release of Records and Information

I _____ (name of client) hereby give permission to George Lynn, M.A. to disclose to/receive from _____ information pertaining to my treatment in counseling conveyed by paper or electronic media to include relevant records.

I may revoke this consent at any time. If I do not revoke it, this consent will expire upon termination of treatment.

Signature of client or parent of client (if client is under the age of 13)

Date