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AUTHORIZATION FOR RELEASE OF INFORMATION

RE:_____

DOB:_____

I authorize an exchange of information between

_____

_____

and Sarah A. Hover, Ph.D.

10340 Democracy Lane, Suite 104

Fairfax, VA 22030

This authorized exchange of information includes

__medical records

__educational/academic records

__psychiatric evaluation

__psychological evaluation

__social history

__neurological eval.

__behavior report

__teacher's report

__other (specify)

For one year unless specified otherwise

Date:_____
Signature:_____