Metrowest NEUROFEEDBACK

Authorization to Receive/Release Medical Information

Client Name: _____

Address: _____

_____

I hereby authorize the release of medical information relating to the above-named person between Metrowest Neurofeedback and the following professionals:

_____ **Telephone #:** _____

_____ **Telephone #:** _____

_____ **Telephone #:** _____

Signed: _____

Date: _____

☐ **Parent**

☐ **Guardian**

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