Sprouts Therapy
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Authorization to Release Client Information

For educational, medical, or related purposes I do hereby grant permission to **Sprouts Therapy, LLC** to release documents/information acquired on the client named below:

Client:
D.O.B:
Address:

Name of Professional/School /Business Permission is granted:

_____

Address: _____

_____

Parent/Legal Guardian Signature _____

Print Name _____Date _____