RELEASE OF INFORMATION

CONSENT TO RELEASE/RECEIVE INFORMATION

I (or we) _____, authorize Bonnie Goodman, MA/CT, to

disclose and receive information in the course of my grief support counseling with:

I (or we) understand that such information will remain confidential between parties mentioned above.

NAME: _____
NAME:_____

SIGNATURE:_____SIGNATURE:
_____

DATE: _____

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