

Mental Health Provider Services Invoice

**Jennifer Woodward, MS, LMFT**

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**LMFT # 114372**

**RELEASE OF INFORMATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, give my consent for Jennifer Woodward to

confer (in writing or verbally) with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

concerning \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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Signature Date

This release will remain in effect for one year from the date signed.