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I hereby authorize Neuropsychology Associates of Fairfax to release my neuropsychological report to the following recipients:

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Agency/Office: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

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Agency/Office: \_\_\_\_\_  
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X \_\_\_\_\_  
SIGNATURE DATE PRINT PATIENT'S NAME