Laili McGrew, LCSW
#LCS16858
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530-564-8680

Release of Information/Authorization to Exchange Confidential Information

I, [Name of Client]

_____

hereby authorize Laili McGrew, LCSW, to exchange confidential information regarding my treatment with [name of the person(s) or entities with which information is to be exchanged]:

_____

This Authorization permits the exchange of the following information:

____Diagnosis
____Progress to Date
____Client Records
____Other:_____
_____

____Treatment Plan
____Dates of Treatment
____Summary of Treatment

I authorize the exchange of the information described above for the following purpose(s):

_____
_____

I understand that I have a right to receive a copy of this authorization if I request it. I also understand that any cancellation or modification of this authorization must be in writing.

_____

Signature of Client or Client's Representative

_____

Date

This Authorization shall remain valid for the extent of treatment.