## Laili McGrew, LCSW 1747 Oak Avenue Davis, CA 95616

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530-564-8680

## Release of Information/Authorization to Exchange Confidential Information

l	
(Name of Client)	(Date of Birth)
hereby authorize Laili McGrew, I	LCSW to exchange confidential information regarding
my treatment with (name of the perchanged)	person(s) or entities with which information is to be
Contact information:	
This authorization permits for the	e exchange of the following information:
Diagnosis	Treatment Plan
Progress to Date	Dates of Treatment
Client Records	Summary of Treatment
Other	
I authorize the exchange of the i	information described above for the following purpose:
_	request a copy of this authorization if I request it. I also or modification of this authorization must be in writing.
Client Signature	Date

This authorization will remain valid for the extent of treatment unless otherwise specified.