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AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION

I hereby do give permission to **Ann E. Drouilhet, LICSW** and:

_____
(Contact Person's Name) phone:
fax:
address:

to mutually exchange any and all information regarding my social, emotional, educational, psychological, and medical histories, including assessments, background, opinions, and any other relevant data necessary to assist in my treatment.

I agree to indemnify and hold harmless all persons and groups named above from any and all liability for claims, actions, damages, or suits arising from or relating to the release or exchange of information made pursuant to this Authorization for Release of Confidential Information. This release is valid for one year.

_____ Date: _____
(Client Signature or Guardian)

_____ Date: _____
(Client Name and D.O.B.)

_____ Date: _____
(Witness Signature)