Marjorie B. Swett, M.S.W.
Licensed Certified Social Worker--Clinical
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CONSENT FOR RELEASE OF INFORMATION

I/We_____, authorize Marjorie B. Swett, M.S.W.,

to obtain/release/exchange _____

from/to/with_____

for the purpose of coordinating treatment and planning.

I understand that this consent will remain in effect for one calendar year, unless I revoke it in writing before then.

_____
(Patient Signature

_____
(Date)

_____
(Witness Signature)