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Release of Information

Client(s) Name(s): _____

Person(s) and/or organization to/from whom information is to be exchanged:

I/we _____, hereby
authorize and consent to the release/exchange of information as deemed pertinent **by** Julie Rappaport,
MA, LPC, **to** the above listed person(s)/organization(s). I also allow the person listed above to disclose
information **to** Julie Rappaport, MA, LPC. Such disclosure of information is for the purpose of
establishing and coordinating an effective treatment plan and continuity of care.

I hereby relieve and release Julie Rappaport, MA, LPC, from any and all damages, claims and causes of
action arising out of or in connection with any release of this information. I understand that my records
are protected under the Federal Confidentiality Regulations and cannot be disclosed without my written
consent. I further understand that I may revoke this consent at any time, otherwise this release will expire
in one year.

Client Signature: _____ Date: _____

Client Signature: _____ Date: _____

Therapist Signature: _____ Date: _____