Julie Rappaport, MA, LPC
737 29th Street #200B
Boulder, CO 80303

jrapp88@gmail.com
303-396-8084
License No. 3684

# Release of Information*

***This form is to be filled out if either/both partners are seeing an individual therapist. If so, please fill in the therapist name(s) in the second section.**

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: _____