Celeste Labadie, LMFT 2769 Iris Ave. #108, Boulder, CO 80304 303.882.3301

AUTHORIZATION TO RELEASE / EXCHANGE INFORMATION

This form provides your therapist with written permission to communicate with other individuals regarding your treatment (e.g., previous therapist, current health providers, parent, or referral therapist).

Client's Name: _____ Date of Birth: _____

I request or authorize CELESTE LABADIE, LMFT
to release or exchange information about my case with the following party:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This authorization applies to the following information:

☐ Intake and History
☐ Treatment progress
☐ Diagnosis and Treatment Plan
☐ Discharge Summary
☐ Billing and Payment
☐ Verbal Consultation
☐ **All of the Above**

☐ Other: _____

Patient Signature: _____ Date Signed: _____

Parent Signature: (If under 18) _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED
or
30 DAYS AFTER TERMINATION OF TREATMENT.