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AUTHORIZATION TO EXCHANGE and/or RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____ Birthdate: _____

By signing this document, I _____ authorize
(Client/Parent/Guardian)
Holly LaBarbera, LMFT, to release and/or exchange the following confidential information regarding treatment:

Diagnostic_____ Legal_____ Psychological_____ Educational_____

Medical_____ Social_____ Observational_____

Other_____

Either by phone, email and/or written reports with:

Name: _____ Title: _____

Phone: _____ Fax: _____

Address: _____

Email: _____

I understand that any cancellation or modification to this authorization must be in writing. This authorization shall remain valid until _____.

_____	_____	_____
Name of Client/Parent/Guardian	Signature	Date

_____	_____	_____
Name of Client/Parent/Guardian	Signature	Date