Celedra Gildea, PhD, MFT(Ca), LPC

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Authorization to Obtain or Release Confidential Information

I (We), _____ give Celedra Gildea, PhD, MFT(Ca), LPC

permission to release information and/or a report about myself (ourselves) to:

_____.

signature:_____ date:_____

signature:_____ date:_____

I (We), _____ give permission, request and direct that

_____

release, copy and forward information and/or report about myself (ourselves) to Celedra

Gildea, PhD, MFT(Ca), LPC.

signature:_____ date:_____

This consent is in effect for one year from the date of signing, unless revoked in writing or until the termination of therapy. I understand that I may revoke this consent at any time. I understand that any cancellation or modification of this authorization must be in writing.

signature:_____ date:_____

signature:_____ date:_____