A HEALING ALTERNATIVE COUNSELING AND WELLNESS CENTER, LLC

8603 CROWNHILL, SUITE 3 SAN ANTONIO, TX 78209

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

I _____ authorize Faith G. Harper to:

_____ release to:
_____ obtain from:
_____ exchange with:
_____
_____
_____
_____

The following information pertaining to myself:
_____ treatment summary
_____ history/intake
_____ diagnosis
_____ psychological test results
_____ psychiatric evaluation/medication history
_____ dates of treatment attendance
_____ other (specify) _____

For the purpose of:

_____ evaluation/assessment and/or coordinating treatment efforts
_____ other (specify) _____

This consent will automatically expire one (1) year after the date of my signature as it appears below, or on the following earlier date, condition, or event _____

I understand I have the right to refuse to sign this form, and that I may revoke my consent at any time (except to the extent that the information has already been released).

_____ _____

Signature of Client
or Legally Authorized Representative

Date