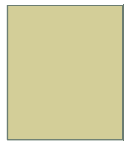


**A HEALING ALTERNATIVE COUNSELING AND WELLNESS  
CENTER, LLC**

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