

**Pastoral Counseling
Marriage & Family Counseling**

Glenn T. Howard, M.Div. LMFT, AAPC

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Consent To Exchange Information

I, _____, hereby consent to the release of privileged information records and waive the privilege of confidentiality afforded for medical and mental health care and alcohol and drug rehabilitation. I authorize **Glenn T. Howard** and

to exchange any information and records for the purpose of enhancing and clarifying my treatment. This information includes, but may not be limited to: test results, notes, diagnoses, treatment plans, or any other type of information. **Glenn T. Howard** is further authorized to release said information and records in writing and verbally. This release is also valid for any drug/alcohol information.

Glenn T. Howard is hereby released from all liability arising out of, or in any way incident to, producing records or providing information pursuant to this authorization. A duplicate, photostatic or facsimile reproduction of this authorization may be used in lieu of the original. This document is a two-way consent, also allowing **Glenn T. Howard** to receive information from the aforementioned entity.

This authorization is subject to revocation in writing only by the undersigned. It will automatically expire one year from the undersigned date, unless previously revoked.

SIGNED _____ DATE _____

PARENT'S SIGNATURE (if client is a minor) _____

Witness _____