

**Meagan Howard, MS, LPC-Intern**  
**Supervised by Debbie Edmunds, MA, LPC-S**

www.H.O.P.E.PsychotherapyOfHouston.com

**Authorization to Release Information**

I, \_\_\_\_\_ authorize

Meagan Howard, MS, LPC-Intern and

\_\_\_\_\_  
(name of person(s) or organization(s) which disclosure is to be made to and/or received from)

to disclose or release **one to the other** the following information from my records:

\_\_\_\_\_  
Initials All Health Care Information

\_\_\_\_\_  
Initials Health Care Information or Opinions Relating to any or all of the following treatment(s) and, or conditions:

\_\_\_\_\_  
Initials 1) Psychiatric or Mental Health Information

\_\_\_\_\_  
Initials 2) Academic and Confidential School Information

\_\_\_\_\_  
Initials 3) Testing

\_\_\_\_\_  
Initials 4) Other \_\_\_\_\_

For the purpose of treatment/management and or supervision or psychological and or medical condition(s), **I hereby waive my right to the privileges of confidentiality as specified above, for a period of one year after termination of treatment, management or supervision unless expressly revoked earlier in writing.**

\_\_\_\_\_  
Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date