# Consent to Release Confidential Information

I understand that the information in the record of

Client Name: _____ D.O.B.: _____

Address: _____

City: _____ State:_____ Zip: _____

Is personal and private; however, I give permission for:

Clinician: Jeremy H. Broussard, PhD, LPC

Address: 404 Pere Megret/ 321 Travis St.

City: Abbeville/Lafayette State: LA Zip: 70511/70503

Office Phone: (225) 573-5140 Fax: (337) 205-7756

to release any information to the identified person or entity:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Office phone: _____ Fax: _____

For the purpose of:

_____

_____

This consent to release is set to expire one year from the date of inception indicated below. By signing this document you are giving Jeremy H. Broussard, PhD, LPC permission to disclose confidential information discussed in therapy to the above identified person or entity.

Client name: _____ Date: _____

Signature of Responsible Party: _____ Date: _____

Clinician Signature: _____