

## 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

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, 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: \_\_\_\_\_