REBECCA LOWRY, MA, LPC

Mutual Exchange of Information

I hereby give my permission for a mutual exchange of information between Rebecca K. Lowry, LPC, and

Name _____

Address _____

_____

_____

Phone _____

Fax _____

concerning the treatment of (including medical, psychological, and/or education records)

Client's Name _____

Address _____

_____

Phone _____

for the purpose of _____.

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it, and, if not revoked sooner in writing, this consent will expire 180 days from the day signed. I understand that I have the right to receive a copy of this consent.

Release or transfer of the above information to any other person or organization is prohibited without an additional written consent authorizing such a transfer.

Client Name_____
(*please print*)

Client Signature_____ Date_____

Parent/Guardian Name_____
(*please print*)

Parent/Guardian Signature_____ Date_____

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