

Kendra Powers, LPC

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RELEASE OF INFORMATION

I hereby authorize, Kendra Powers LPC of Thriving Life Counseling to
release or gain all medical, psychological, and or educational information

pertaining

To (Client's Name) _____

From(Person's Name Client authorizes) _____

for the purpose of providing consistency and understanding for current

and

future individual, couples, family and / or group therapy sessions.

Clients's Signature

Date

Rescinded

Date