Authorization for Release of Hypnotherapy Information

Client Information:

Client Name: _____ Date of Birth: _____

Client Address: _____

Client Home Phone: _____ Client Cell Phone: _____

Client Email Address: _____

Recipient Information:

I, _____, do hereby authorize _____ to release information from my records (or my child's records) to the person or agency below.

Authorized person/agency to receive information: _____

Phone: _____ Address: _____

Date of Authorization: _____/_____/_____

Authorization to expire on ___/___/_____ or upon the happening of the following event:

_____

Information to be Released:

I give permission to _____ and the person or agency authorized above to share the following information:

☐ My entire hypnotherapy record
☐ Only those portions pertaining to: _____
(Specific provider name and/or dates of treatment)
☐ Other (specify): _____

Purpose of Information Release:

☐ Enhance client care ☐ Individual's request ☐ Other (specify): _____

Authorization for Release of Hypnotherapy Information

Authorization and Signature:

I authorize the release of my confidential hypnotherapy information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed may not be released to any other person or organization without my permission in writing, and that the use/disclosure is to be made to conform to my directions. A photocopy of this authorization shall be considered valid.

Signature: _____ Date: _____

If signed by a personal representative:

a. Print your name: _____
b. Indicate your relationship to the client and/or reason and legal authority for signing:
   Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased
   Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased