Authorization for Release of Information

I. Client Information:

Client Name: _____ Date of Birth: _____

Client Address: _____

Client Home Phone: _____ Cell/Work Phone: _____

II. Recipient Information:

I authorize Hypnodipity to release information from my records to the person or entity below.

Name of person/entity to receive information: _____

Address: _____

Phone: _____ Email or Fax: _____

III. Information to be Released:

I give permission to Hypnodipity and the person/entity listed above to share the following information:

- ▢ Educational
- ▢ Medical
- ▢ Psychological
- ▢ Psychiatric
- ▢ Social
- ▢ Psychometric
- ▢ Other (specify): _____
- ▢ Care Coordination / Case Management
- ▢ Medication Management Information
- ▢ Participation in Hypnotherapy Program
- ▢ Treatment Plan or Summary
- ▢ Progress Reports or Updates
- ▢ Discharge/Transfer Summary

IV. Purpose of Information Release:

This information may be used or disclosed in connection with alternative and holistic health services for the purposes of Vocational or Avocational Self-improvement and/or coordinating care for problems of psychogenic or functional origin with proper psychological or medical referrals only (Business and Professions Code 2908).

If the purpose is other than as specified above, please specify:

_____

_____

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V. Expiration of Authorization

I understand this Authorization will automatically expire on _____ / _____ / _____, or six months from the date of execution of this Release, whichever is later.

VI. Other Important Information

By signing this Authorization, I understand that:

- I authorize the use or disclosure of my confidential information as described above for the purpose listed. This information may not be released to any other person or entity without my permission in writing, unless required or permitted by law.
- I have the right to withdraw permission for the release of my information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing to Niki at niki@hypnodipity.com, and will not affect information that has already been used or disclosed.
- This Authorization is voluntary, the use or disclosure is made to conform to my directions, and I do not need to sign this Authorization in order to receive services.
- I have a right to receive a copy of this Authorization. A copy of this Authorization shall be considered as valid as the original.
- A person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law

VII. Authorization and Signature

I have read and understand the content of this Authorization. I am signing the Authorization voluntarily and understand that I have the right to refuse to sign this document. My signature authorizes the disclosure of my private and confidential information as described in Section III of this Authorization.

Name and Signature of Client or Client's Legal Representative:

_____	_____	_____/_____/_____
Print Name	Signature	Month Day Year

If signed by Client's Legal Representative, state relationship and authority to do so:

_____

Witness: Name and Signature of Service Provider or Agency/Clinic Representative:

_____	_____	_____/_____/_____
Print Name and Title	Signature	Month Day Year

_____

Provider Address