Authorization for Release of Information

Mind Body Mentors - Baltimore, Maryland

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

Client name: _____

Birth date: _____

Client Address: _____

I hereby authorize *Mind Body Mentors* or *Courtney Miller* to:

(Check all that apply)

- ❏ Exchange information with _____
- ❏ Release information to _____
- ❏ Obtain information from _____

I hereby authorize *Mind Body Mentors* or *Courtney Miller* to exchange / release / obtain information:

- ❏ Verbally
- ❏ In written form only
- ❏ Both verbally and in writing

To or from the person / organization receiving / communicating the information:

Name: _____

Address: _____

Phone Number: _____

Note: The release of information form is only given to co-therapist when permission is needed for another provider to speak with you, or when you need to speak to another provider.

Description of Specific Information to be either:

Released / exchanged / obtained:

_____

_____

_____

The specific purpose of this release is to:

_____

_____

_____

This authorization expires on: _____

I have read and understand the following statements about my rights:

I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.

I may see and copy the information described on this form if I ask for it.

I am not required to sign this form to receive hypnotherapy services.

Client signature: _____

Today's date: _____