



Client/Patient Consent to Release Information

Client/Patient Name: _____

Date of Birth: _____

This consent to release information authorizes information from my records and conversations to be shared between:

Clinical Hypnotherapist

Therapist

I understand that this authorization is valid for as long as I am under the therapist's care. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

Signature of Client/Parent/Guardian DATE

PRINTED NAME