

VRishi Immersive Hypnotherapy

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Consent to Release Confidential Information

Client Name:

Date of Birth:

This consent authorizes the release and exchange of confidential information from my records (or my child's records) between:

Hypnotherapist:

and

Medical Doctor/Therapist/Agency:

I understand that this authorization is valid for six (6) months from the date below. I also understand that this information may not be released to any other person or organization without my written permission. A photocopy or electronic copy of this authorization shall be considered valid.

Medical Doctor/Therapist/Agency:

Street Address:

City/State/Zip:

Signature of Client/Parent/Guardian:

Printed Name of Client/Parent/Guardian:

Date:

Client Signature

Date