CONSENT TO RELEASE INFORMATION

Client Name: _____ Date of Birth: _____

This consent to release information authorizes information from my records (or my child's records) to be shared between Mark Hilyard, C.Ht and the agency/school listed below.

I give permission to Hilyard Hypnotherapy and the agency/school listed below to share the following information:

___ Educational ___ Psychiatric ___ Medical

___ Social ___ Psychological ___ Psychometric

I understand that this authorization is valid for six months from the date below. 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.

_____ _____

Agency or School Name Individual

_____

Street Address

_____ _____ _____

City State Postal

_____ _____

Printed Name of Client/Parent/Guardian Date

_____ _____

Signature of Client/Parent/Guardian Witness (counselor)

HILYARD HYPNOTHERAPY
8201 MAIN ST SUITE 7
WILLIAMSVILLE, NY 14221