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 ____
Therapist

And the agency/school listed below.

I give permission to Hypnosis Motivation Institute 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 Date

_________________________________ ____________________________________
City/State Zip Witness (counselor)

__________________________________ ____________________________________

Signature of Client/Parent/Guardian Printed Name of Client/Parent/Guardian

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