



AUTHORIZATION TO RELEASE AND/OR DISCUSS SESSION INFORMATION AND OTHER PROTECTED HEALTH INFORMATION

CLIENT NAME: _____ **DOB:** _____

ADDRESS: _____

I hereby authorize you to: (please check all that apply)

- Release to:** Lori Nicholson, Certified Hypnotist, Well Awakened Hypnosis, 4235 Headwaters Lane, Olney, MD 20832, 301-365-2428, lori@wellawakenedliving.com
- Obtain from:** Lori Nicholson, Certified Hypnotist, Well Awakened Hypnosis, 4235 Headwaters Lane, Olney, MD 20832, 301-365-2428, lori@wellawakenedliving.com

The following information (please note “All” or specify dates on the lines next to the information desired):

- Intake summary _____
- Discharge summary _____
- Session notes _____
- Dates of visits _____
- Recommendations _____
- Hypnotists’ assessment of client’s participation in action plan _____
- General progress _____
- Other (please specify): _____

This information is needed for the purpose of: _____

- I understand that if the person or agency that receives my information is not a health care provider or health plan covered by the HIPAA privacy regulations, the information described above may be re-disclosed and is no longer protected by these regulations.
- I understand that written notification is necessary to cancel this authorization. This consent is automatically cancelled 12 months after date signed.
- I hereby hold harmless Well Awakened Hypnosis, Well Awakened Living and/or Lori Nicholson and any of her family, employees, and associates for any and all results which may occur due to the release and/or discussion of my session and treatment information with any other health care providers.

DATE: _____

CLIENT SIGNATURE: _____

WITNESS SIGNATURE: _____