Well Awakened Living
With Lori Nicholson

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

Care Provider's Name, Practice Name, Address, Phone Number, Web Address (for Your Care Provider):

_____

_____

_____

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: Coordinated care between hypnotist and care provider

- 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: _____