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 Intelligence and 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 release to any other person or organization without mt permission in writing. A photocopy of this authorization shall be considered valid.

_____	_____
Agency or School Name	Individual
_____	_____
Street Address	Date
_____	_____
City/State Zip	Witness (counseler)
_____	_____
Signature of Client/Parent/Guardian	Printed Name of Client/Parent/Guardian