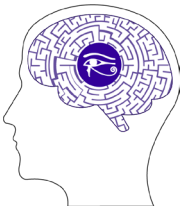

# Authorization for Release of Information

Cory S. Brown, CMS-CHt, FIBH
Labyrinth Hypnotherapy

I hereby authorize the use or disclosure of my individually identifiable health information as described below.

I understand that this authorization is voluntary, and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

**Client name:**

**Client Birth date:**

**Client Address:**

I hereby authorize Cory S. Brown, CMS-CHt of Labyrinth Hypnotherapy to (check all that apply):

_____ Exchange information with _____

_____ Release information to _____

_____ Obtain information from _____

I hereby authorize Cory S. Brown, CMS-CHt of Labyrinth Hypnotherapy to exchange/release/obtain information:

☐ Verbally ☐ In written form only ☐ Both verbally and in writing

to or from the person/organization receiving/communicating the information

**Name:**

**Address:**

**Phone number:**

**Email address:**

Description of Specific Information to be either:

Released/exchanged/obtained:

The specific purpose of this release is to:

I have read and understand the following statements about my rights:

I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took before it received the revocation.

I may see and copy the information described on this form if I ask for it.

I am not required to sign this form to receive hypnotherapy services

Client Signature*: _____

Date: _____