



David A. Blender, CPC, CCH, CH

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Hours By Appointment Only.

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 _____
Hypnotherapist

And the agency/school listed below.

I give permission to Hypnotic Therapeutics 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