Authorization for the Release and/or Discussion of Protected Health Information

Client Name:_____ SS#: _____-____-_____Birth Date: __/___/____

Authorization

I _____, (Name of Client or Client's Legally Authorized Representative)

hereby authorize Rachel Rice and Five Rhythms Consulting, located at 9 Heard Road, Wayland, MA 01778

to release and/or discuss the record and treatment plan update of the Client

to _____of

_____.
{name, address and phone of organization]

This authorization expires ____6 months ____one year from today's date, or upon the

following specified event: _____.

I am aware that information regarding my energy medicine and/or energy psychology sessions will be released to those persons or agencies named above. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I understand that this consent is subject to revocation, in writing, at any time, unless action based on it has already begun.

This information release is at my request. I authorize the use of a copy of this form for the disclosure of the information described above.

Signed _____

Relationship_____ (self, parent, guardian)

Date: ___/___/___