Release of Information

Clients Name:

Therapist Name:

The above-named client authorizes the above-named therapist and TMT Clinic to meet with, send, receive, and share confidential information from my trauma-sensitive bodywork sessions with the following individuals or entities: therapist, social worker, agency, bishop and their executive assistants, doctor, or any other entity or individual as listed below:

I authorize the following individual:

Name**:**

Phone Number**:**

Email Address**:**

Address**:**

I understand this agreement is valid for one year from the date signed below unless I provide written notice to revoke this authorization for the release of information.

I agree: Initials _____

Client Signature: _____

Date: _____