Waiver and Release from Liability for Trauma-Informed Somatic Bodywork

I acknowledge that Lelia Maloney, owner of Taylors Massage Therapy Clinic, is a Trauma-Informed Somatic Bodywork Therapist in private practice who provides mental, emotional, physical, and spiritual support utilizing the EAR System (Education, Awareness, and Responding), Somatic Experiencing® principles, and Somatic Emotional Release techniques.

I understand that while Mrs. Maloney is a licensed massage and bodywork therapist, she does not hold medical or mental health licensure and does not offer medical diagnoses or psychological treatment. I agree to consult my own healthcare providers for any medical or psychological concerns.

Her services are designed to facilitate emotional regulation and enhance body awareness through therapeutic touch and somatic presence. I recognize that any insights or strategies offered by Mrs. Maloney are provided as supportive suggestions rather than prescriptive directives, and I may choose whether to incorporate them.

I accept responsibility for communicating my comfort levels and relevant personal history, understanding that either party may terminate the session at any time.

In consideration of receiving these services, I hereby release and hold harmless Lelia Maloney and Taylors Massage Therapy Clinic from all liability related to the provision of trauma-informed somatic bodywork. This waiver extends to myself, my heirs, next of kin, executors, administrators, and assigns.

I confirm that I have read and understood this Waiver and Release, and by signing below, acknowledge that I waive certain legal rights available to me or my representatives.

Printed Name _____

Signature _____ **Date** _____

(Optional) Release of Information -The above-named client authorizes Lelia Maloney, owner of Taylors Massage Therapy Clinic to meet with, send, receive, and share confidential information from trauma-informed somatic bodywork sessions with the following individuals or entities: therapist, social worker, agency, bishop and their executive assistants, doctor, or any other individual or organization listed below.

Authorized individuals or entities:

Name: _____Phone Number: _____

This authorization remains valid for one year from the date signed below unless revoked in writing.

By initialing below, I authorize the release of information as described above.

Initials: _____