944 New Britain Avenue
West Hartford, CT 06110

LIFE COACHING THERAPY LLC

203-733-9600
info@sexandmagic.com

RELEASE OF INFORMATION

Client Name: _____ DOB: _____

Legal Name (If Different): _____

Name of Guardian (If Applicable): _____

I authorize Life Coaching and Therapy LLC
to disclose and/or obtain treatment information from the following:

Name
……....
Address
……....
Phone
……....
Email
……....

Please sign below if you agree to release ALL your Protected Health Information.

If you are limiting the information that is released, please list ONLY the information you agree to be released:

By signing below, I acknowledge that the above information about me may be released, discussed, or disclosed. I understand that my records are protected under Federal Regulations governing Confidentiality of Protected Health Information (PHI) under HIPAA and cannot be disclosed without my consent unless otherwise provided for the regulations.

I also understand that I may revoke this authorization at any time and must do so in writing and present this written revocation to my therapist. I understand that once information is disclosed as per my authorization, the recipient, in accordance with applicable laws and regulations, may re-disclose the information and it might not be protected by federal or state privacy regulations. This release of information will remain in effect until revoked in writing or until 30 days after ending services.

Signature of Client: _____ Date: _____

Signature of Guardian (If Applicable): _____ Date: _____