AUTHORIZATION FOR RELEASE OF INFORMATION

Name _____

Date of Birth _____

I hereby authorize the use or disclosure of personal and private health information I have provided to _____ in order for them to provide services as a Plant Spirit Medicine healer subject to conditions set forth below. This authorization permits _____ to share this information with other individuals or practitioners they may choose to assist with or follow-up with the services for which they are the primary provider. This authorization is voluntary. I understand that the released information may not be protected by federal privacy regulations following disclosure.

Persons authorized to receive information:

Information to be disclosed includes the following:

I understand that this Authorization will expire one year from the date of its execution.

I understand that I may revoke this Authorization at any time by notifying the provider in writing, but if I do so it will not have any effect on any actions taken before the revocation was received.

_____ _____

Signature of Client Date