



building calm

life coaching

Building Calm Life Coaching Authorization for Release of Information

Client's Name:

DOB:

Information to be released:

Summary of treatment to date

Report

Other

Purpose of Disclosure:

Coordination of Care

Other

Persons authorized to make Disclosure:

Person authorized to receive Disclosure:

Method of Disclosure:

Written

Verbal

Electronic

Today's date:

Authorization to expire on:

I understand that my health information is protected by law. I authorize the release of my confidential health information as indicated above. I understand that my consent is voluntary and I can revoke this permission at any time, except to the extent that it has already been shared based on this authorization. Should I choose to revoke this authorization I will state this in writing.

Signature of Patient

Signature of Personal Representative