AUTHORIZATON FOR RELEASE OF INFORMATION

I (We) authorize Gary J. Coenen, M.S. of LifeStyle By Choice, 313 Price Place, Suite 206, Madison, WI. To release specific information to include:

_____

_____

From the clinical record of _____
(Name of client/recipient of Clinical Hypnosis / Counseling Services) (Date of birth)

For the purpose of

_____

_____
(Facilitating counseling/consultation, and/or conducting an evaluation, etc.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending notice toGary J. Coenen of LifeStyle by Choice. I understand that a revocation is not valid to the extent that Gary J. Coenen of LifeStyle by Choice has acted in reliance on such authorization.

This authorization is valid until

_____.

It has been explained to me that If I refuse to consent to this release of information, the following are the consequences, if any:
A copy of this release shall have the same force and effect as the original.

(Client Signature(s)) _____ Date _____
_____ Date _____

_____ _____ _____ _____
(Clients Signature 12 yrs. or older) (Date) (Parent/Guardian Signature) (Date)

NOTICE TO RECEIVING FACILITY/THERAPIST: You may not re-disclose any of This information unless the person who consented to this disclosure specifically consents to Such re-disclosure. I understand that there is a potential for re-disclosure of this information By the recipient and, if that occurs, the information may not be protected by Federal law.