Clinical Release Form

Your healing sessions are personal and private. As a part of your healing process, however, you may wish and find it helpful for us to exchange information with other services providers or family members of yours. Please complete and sign the form giving us permission.

Your Name: ____

I hereby request For The Love Of Healing, LLC to release any and all information about me, as authorized below, to:

Name: ____

Address:

Phone: ____

Email: ____

The request and authorization applies to:

☐ Information relating to the following treatment, condition, or dates (please describe):

☐ All information

Your Signature: ___________________________________

Date: ____________________________

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