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AUTHORIZATION TO DISCLOSE INFORMATION

Client Name _____

Date of Birth: _____

Address _____

Phone _____

I authorize Teena Evert MA, CSIP, RYT to make contact by phone, in writing or in person with _____ *(name of other professional)* and to release any and all information concerning me as may be necessary and/or helpful in my clinical evaluation, treatment planning and treatment activity.

I also authorize _____ *(name of other professional)* to release any and all information requested by Teen Evert, MA, CSIP, RYT.

It is my intention that the professionals with whom I have been in treatment and with whom I am currently in treatment to be able to freely exchange information in order to best serve me.

I understand that the information released by this authorization may include information concerning treatment of psychological issues. I understand that this authorization will expire, without my express revocation, one year from the date of signing. I understand that this authorization of this information is voluntary and I can refuse to sign this authorization or revoke it in writing at any time.

Signature of Client

Date

Teena Evert, MA, CSIP, RYT

Date