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 and authorize the AHP Enterprises, Inc. to release any and all information about me to:

Name: ____

Address:____

City:____________________ State:_________________ Zip Code:_________

Phone:__________________

The request and authorization applies to:

☐ Information relating to the following treatment, condition, or dates:

____

____

____

☐ All information

☐ Other

Client's Signature: ____

Date: ____

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