CORE CONSTELLATIONS
CENTER FOR BODY, MIND & SOUL
1107 Nelson Street, Suite #204
Rockville, MD 20850

Authorization for Disclosure of Confidential Information

Kuno Bachbauer, MD (Austria), LMFT (DC), Certified Core Energetics practitioner, has my permission to provide/obtain verbal or written information relevant to my sessions to/from:

NAME (Practitioner/Agency): _____

ADDRESS: _____

CITY, STATE, ZIP: _____

Telephone: _____ E-Mail: _____

The use of this information is restricted to the following purposes:

_____

_____

This information cannot be re-disclosed to another party without my written authorization.
I understand that by law I have the right to inspect my record of mental health information and that I may revoke this authorization in writing at any time.

SIGNATURE OF CLIENT: _____ DATE: _____

PRINTED NAME: _____ DATE OF BIRTH: _____

Expiration of Authorization:

Unless previously revoke, this authorization will expire on _____ or with the termination of treatment, if earlier than the expiration date.

_____