Trinity Healing &Wellness Center, Inc.

Toni Hemmerich, Ph.D., LPCMH, NCC

I, _____(client) hereby authorize Dr. Toni Hemmerich, (psychotherapist), to disclose mental health treatment information and records obtained in the course of psychotherapy and Reiki treatment of Client, including, but not limited to therapist's diagnosis of Client, to:

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless psychotherapist has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by the psychotherapist at 900 Philadelphia Pike, Suite C, Wilmington, DE 19809, to be effective.

This disclosure of information and records authorized by Client is required for the following purpose:

The specific uses and limitations of the types of medical information to be discussed are as follows:

Such disclosure shall be limited to the following specific type of information:

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to this form.

Client understands that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

This authorization shall remain valid until:_____

Client's signature:_____

Date:_____

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