Intentions Yoga

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

I, _____, authorize *Cynthia N. Herzog, LCSW*, to exchange the following types of information for the following purposes:

CLINICAL INFORMATION

Vista may exchange with *Lorraine Turner*, information relating to the clinical / yoga services I receive and to support continuity of care.

MANAGED CARE

Vista may transmit to the entity(ies) responsibility for payment of claims under my health benefit plan any information bearing on coverage by such plan of treatment to be offered by a health care provider to whom I am being referred by Vista, to assist in coverage determinations.

This authorization shall become effective _____ and is subject to revocation in writing by me at any time, except tot he extent that action has already been taken. This authorization shall terminate two (2) years from the effective date, if not earlier revoked. I understand that this information will be used only for the purpose noted above and will not be disclosed to any other person or agency without my written permission.

_____ _____

Signature of Client or Legal Guardian Name of Client

_____ _____

Witness Date

101 Timberlachen Circle, Suite 201, Lake Mary, FL 32746
Cynthia N. Herzog, LCSW, CAP, ICADC, CIAYT, 500 E-RYT
www.vistaeap.com Phone: (407) 324-9440
Lorraine Turner, 500 E-RYT, Y4C Phone: (407) 687-4414