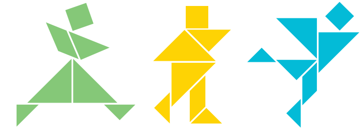

Arts for Replenishment & Change
Therapy for a Fresh Perspective

# Permission for Release of Information

I, ________________________ , hereby grant permission to Dr. Annie Ready Coffey to exchange verbal and/or written information with ________________________ regarding the treatment of myself or the treatment of my child(ren), ________________________ .

I understand that this permission will be in effect for one year from the date of my signature below or, if I elect to remove the permission, no further communication will be authorized as soon as I have communicated this to Dr. Coffey.

Permission for
release of information: __________________________________ Date: _____________
*Signature of patient or patient's parent/guardian*

Please print this form, complete, and bring with you on your first visit.

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