



Holistic Health & Healing

Home of Power of the Mind Healing Center

Counseling, Hypnotherapy, Meditation, Scenar® Therapy (pain), Tuning Fork Cymatic Therapy, WC™ Laser Therapy, Transcutaneous Acupuncture™, Life Coaching, Acupressure, Essential Oils, Skype/Phone Therapy, EFT, Chakra & Energy Healing, Angel/Oracle Card Readings Biofeedback, Neural Efficiency Optimizer, Transcranial Therapy, and Neurotherapy

Dr. Sharon A. Jackson, Ph.D.

Metaphysician, Counseling Psychologist, Certified Clinical Hypnotherapist, Holistic Practitioner
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CONSENT TO RELEASE INFORMATION

Client Name: _____ Date of Birth _____

This consent to release information authorizes information from my records (or my child's records) and may be shared between **Holistic Health & Healing, Power of the Mind Healing Center, Healing Light Ministries, Dr. Sharon Jackson, Therapist**

And, the agency/school listed below.

I give permission to Holistic Health & Healing - Power of the Mind Healing Center and the agency/school listed below to share the following information:

<input checked="" type="checkbox"/> Educational	<input checked="" type="checkbox"/> Psychiatric
<input checked="" type="checkbox"/> Medical	<input checked="" type="checkbox"/> Social
<input checked="" type="checkbox"/> Psychological	<input checked="" type="checkbox"/> Psychometric

I understand that this authorization can be cancelled at any time. I also understand that this information may not be released to any other person or organization without my permission in writing. A photocopy of this authorization shall be considered valid.

Agency or School Name _____

Individual _____

Street Address _____

Date _____

City/State _____ Zip _____

Witness (counselor) _____

Signature of Client/Parent/Guardian _____

Printed Name of Client/Parent/Guardian _____