*******EFFECTIVE DATE: 03/01/2025*******

Clients will receive a signed copy of this agreement.

Release of Medical Information

Client Acknowledgement:

By signing this form, I, the undersigned, acknowledge that I have been informed that all personal and medical information shared with Akina's Garden Healing is protected and confidential. I consent to the use of my medical and health information only for the purposes outlined below.

1. Purpose of Release

I hereby authorize Akina's Garden Healing to release my medical and health information for the following purposes (check applicable):

[ ] Health and Wellness Consultation

[ ] Holistic Healing and Treatment Plans

[ ] Sharing Information with Other Healthcare Providers

[ ] Other (Please specify): _____

2. Information to be Released

I consent to the release of the following types of medical and health-related information (check applicable):

[ ] Medical History

[ ] Treatment Plans

[ ] Diagnosis

[ ] Lab Results/Tests

[ ] Other (Please specify): _____

3. Parties Authorized to Receive the Information

I authorize the release of my medical and health-related information to the following individuals or organizations (check applicable):

Akina's Garden Healing and its Staff

Other Healthcare Providers/Practitioners (List Names if applicable): _____

4. Confidentiality of Information

I understand that Akina's Garden Healing will make every effort to protect the confidentiality of my medical and health information and will not share it with others

without my explicit consent, except where required by law. I am aware that this information will be stored securely, and access will be limited to authorized individuals.

5. Right to Revoke

I understand that I may revoke this authorization at any time by submitting a written notice to Akina's Garden Healing. Such revocation will not affect any actions taken before the revocation.

6. Limitation of Liability

I understand that Akina's Garden Healing will use reasonable efforts to protect my confidential information but cannot be held liable for the unauthorized use or disclosure of such information by third parties, once it has been disclosed as authorized by me.

7. Expiration of Authorization

This release authorization will remain in effect until I choose to revoke it in writing, or until it is otherwise terminated in writing by Akina's Garden Healing.

8. Client’s Acknowledgement

By signing below, I confirm that I have read and understand the contents of this document. I acknowledge that I will receive a signed copy of this agreement.

Client Name: _____

Date of Birth: _____

Signature of Client: _____

Date: _____

Signature of Practitioner/Authorized Representative: _____

Date: _____