Steffensen
CONSULTING
Somatic Experiencing®

AUTHORIZATION CONSENTING TO RELEASE OF INFORMATION

I authorize **Taruno Steffensen, ICADC, SEP, CSAT** to **discuss** (verbally or in writing) anything that has been brought up during our Somatic Experiencing Session or consultation/evaluation **with** any person/s or staff of clinic, office, agency, or institution/s named below and **receive** any relevant information **from** them.

1. _____

2. _____

3. _____

4. _____

5. _____

For the following reason(s):

☐ Consultation

☐ Evaluation

☐ Other: _____

I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed. This consent is also subject to all conditions outlined in the Office Policies form.

_____	_____	_____
Client Printed Name	Date	Client Signature

_____	_____	_____
Practitioner Printed Name	Date	Practitioner Signature