Release of Information for Dr. Lyman Coaching Services, LLC

Client Name: _____
Date of Birth: _____
Parent/Guardian Name (if applicable): _____
Phone Number: _____
Email: _____

I, _____, authorize Dr. Lyman, an individual and family coach, to release and/or obtain information related to my coaching services as described below. I understand that this information will be used to support my personal and family coaching process.

Purpose of Release

- To coordinate care and services
- To provide relevant information to designated individuals or organizations
- Other (please specify): _____

Information to be Released (check all that apply)

☐ Coaching session summaries
☐ Progress updates
☐ Goals and action plans
☐ Scheduling and attendance records
☐ Other (please specify): _____

Person(s) or Organization(s) Receiving Information

Name: _____
Relationship to Client: _____
Phone: _____
Email: _____

Confidentiality & Revocation

I understand that this authorization is voluntary and that I have the right to revoke it at any time by submitting a written request to Dr. Lyman. Revocation will not affect any information shared before the request was received. I understand that my information will be handled in accordance with confidentiality policies, but once released, it may not be protected by privacy laws.
This release is valid until (expiration date) _____or until I choose to revoke it.

Acknowledgment and Signature:
By signing below, I acknowledge that I understand the terms of this release and authorize the disclosure of information as outlined above. *

Client Signature: _____
Date: _____
Parent/Guardian Signature (if applicable): _____
Date: _____
Coach Signature: _____
Date: _____

*If you have any questions regarding this authorization, please discuss them before signing.