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

Clients will receive a signed copy of this agreement.

Confidentiality Form

Confidentiality of Information:

I understand that all personal and medical information shared with Akina's Garden Healing will be kept confidential and will only be used for the purpose of treatment, consultation, and holistic healing services. This information will not be disclosed to any third party without my written consent, except as required by law.

Limitation of Liability:

I understand that Akina's Garden Healing is not liable for the unauthorized use or disclosure of my confidential information once it has been shared as authorized by me.

Authorization to Share Information:

I authorize Akina's Garden Healing to share my information with the following entities (check applicable):

Health Care Providers/Practitioners (list names if applicable): _____

Other (please specify): _____

Expiration of Authorization:

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

Client's Acknowledgement:

I acknowledge that I have been informed of my rights to confidentiality and the conditions under which my information may be shared. By signing below, I confirm that I have read and understood this document and 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: _____