Volunteer Release Form for Integrative Chakra Therapy®

Release Form: for Media Recordings

I, the undersigned, do hereby consent and agree that *Gaia Natural Therapies* and *Light News Institute* (hereafter known as *GNT and LNI*), its employees, or agents have the right to take photographs, videotape, or digital recordings of me during all classes and practice sessions. GNT/LN can use any and all media, now or hereafter known, exclusively for the purpose of educational training and promotional footage for GNT/LNI.

Yes: ____ (initials) I consent No: ____ (initials) do not consent

Yes: ____ I further consent that my identity may be revealed therein or by descriptive text or commentary

No: ____ I do not consent that my name and identity be revealed therein or by descriptive text or commentary

I do hereby release to *GNT/LNI*, its agents, and employees all rights to exhibit this work in print and electronic form publicly or privately and to market and sell copies. I waive any rights, claims, or interest I may have to control the use of my identity or likeness in whatever media used.

I understand that there will be no financial or other remuneration for recording me, either for initial or subsequent transmission or playback.

I also understand that *GNT/LN* is not responsible for any expense or liability incurred as a result of my participation in this recording, including medical expenses due to any sickness or injury incurred as a result.

I represent that I am at least 18 years of age, have read and understand the foregoing statement, and am competent to execute this agreement.

Print Full Name: _____ Date: _____

Address: _____

Preferred Phone: _____

Signature: _____

Witness: Print Full for Individual Under 18 years of age Name:

_____

Signature:

_____

Volunteer Release Form for Integrative Chakra Therapy®

Integrative Chakra Therapy® (ICT) (Chakra Balancing and Subtle Energy Medicine Healing) is a non-invasive powerful healing modality that works at the level of the chakra system. The chakra system includes seven major energy consciousness centers located at specific locations along the spine i.e.: from the bottom of the spine to the top of the head. The intention of the ICT session is to help energetically balance any individual mental, physical, emotional, and spiritual issues.

I understand that as part of the ICT process there may be a need for a "laying on of hands" (light touch) and give consent to such light touch as deemed necessary by the practitioner. If for any reason I am or feel uncomfortable during my treatment, I will let the practitioner know and the treatment will be altered, or the session will be terminated. **___ Initial**

It has been made clear to me that Integrative Chakra Therapy® is not a substitute for any medical examinations and/or diagnoses and that it is recommended that I see a physician for any physical ailments(s) that I might have. **___ Initial**

I understand that ICT is designed to be a complementary health aid and in no way will take the place of a physician's care when a physician's care is indicated. All comments or concerns relating to the healing session by the students and/ or Light News teaching staff are not to be interpreted as a medical diagnosis.

I understand that there will be ***no*** diagnosis of illness, disease, or any other physical or mental disorder. I understand that there will be no prescribed medical treatment or pharmaceuticals and there will be **no** massage or any manipulation of the spine.

As part of the student's experiential learning experience, I consent to an open classroom feedback discussion of their findings and recommendations. **___ Initial**

I understand that any and all information exchanged during any session is <u>educational and confidential in nature and is intended to help me become more familiar with and conscious of my own spiritual path, health status, and is to be used at my own discretion.</u> With this in mind, I agree that Integrative Chakra Therapy® by a supervised student, and /or GNT and LNI teaching staff, and /or Deirdre Leighton cannot be held liable for any problems that might arise that I think could be attributed to the energy healing session.

My questions have been answered to my satisfaction regarding my Chakra Balancing and Spiritual Energy Medicine Healing session and what I might expect from this session.

I have read this form and I understand and agree to the policies described herein. **___ Initial**

By my signature below, I hereby authorize Integrative Chakra Therapy® by a supervised student and/ or GNT and LNI teaching staff and /or Deirdre Leighton to administer ICT as they deem necessary.

Volunteers Name (please print):

Signature: _____ Date: _____

Witness Name (please print): _____

Witness Signature: _____ Date: _____