

**Release Form**  
**Family Constellations Training 2012**

In order to attend any of the training weekends being offered in Bert Hellinger's systemic phenomenological approach to healing, the following form must be completed in full. Please read the statement carefully.

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/St/Zip: \_\_\_\_\_

Phone/Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**LOCATION: Hellinger Institute of DC**  
**4803 Saint Elmo Avenue**  
**Bethesda, MD 20814**

***All trainees' attendees are requested to sign below in order to participate.***

I understand that this training may bring up issues of a highly personal nature that may cause me to experience emotional or physical responses that may be unexpected and/or unpleasant. Further, I understand that I may experience mental, emotional, physical, or spiritual distress and that such distress may also cause unpleasant symptoms. What is experienced in this training may create physical manifestations on my part or on the parts of other participants; I understand that there is risk of accident, injury, and emotional distress. I agree to assume this risk, including but not limited to the types of responses and manifestations described. I confirm that I do not currently suffer from any mental or physical impairment, and have not been diagnosed in the past with any disorder, condition, or injury, either physical or mental, that might make it unadvisable for me to assume such risks.

I agree to respect the confidentiality of any disclosure made within the course of this training and will not discuss any details of the work outside the meeting space.

This training is not designed as a substitute for therapy or as a substitute for any other professional consultation. It is designed as an education venue only.

By signing this document below, I willingly agree to hold harmless and release from all liability the organizers, facilitators, and participants in this training, including Susan Ulfelder, John Ulfelder, the Hellinger Institute of DC, and the facility where the training is being offered.

Participant signature \_\_\_\_\_ Date \_\_\_\_\_

Name of Participant (please print) \_\_\_\_\_

**Hellinger Institute of DC**  
4803 Saint Elmo Avenue, Bethesda, MD 20814  
301-215-9168 Fax 301-215-9192  
[HellingerDC@aol.com](mailto:HellingerDC@aol.com)