Massages with Purpose
... Where Healing Begins

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

NOTE: Copy Fee May Be Charged For Medical Records

Client's Name _____ Date of Birth _____

Phone (H) _____ (C) _____

Address _____ City/State/ Zip _____

I hereby authorize Massages with Purpose, Inc. to release copies of all medical records compiled during all office visits to

Name/ Office _____

Address _____City/ State/ Zip _____

Telephone: _____ Facsimile: _____

Primary Email: _____Secondary Email: _____

I understand that authorizing the disclosure of my health information is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. By signing below, I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of client Date

_____

Printed name of client

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