Medical Information Release Authorization

Patients Name: _____ DOB: _____

Address: _____

I, _____, hereby authorize _____
Patient Name Facility which has information

to release any and all pertinent health and medical information including diagnoses, tests, lab reports, prescriptions, procedures, and notes to _____.
Massage Therapist / Business Name

This release of information will remain in effect until terminated by me in writing.

Please initial each to verify that by signing this authorization you understand:

_____ I have the right to receive a copy of this authorization
_____ I authorize the disclosure of my identifiable health information as described above.
_____ I have the right to terminate this authorization and revoke permission to release information. The revocation must be made in writing and will not affect information that has already been disclosed.
_____ I understand that the person to whom my medical information is disclosed pursuant to this agreement may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is required by law.
_____ I am signing this authorization voluntarily.

Please initial one:

_____ Mail to Address: _____

_____

_____ Fax #: _____ _____ Email: _____

_____ Hold for Pickup _____ Discuss health information verbally

_____ _____
Patient Signature Date