Release of Information Authorization Form

Client Information

Client Name: _____ Date of Birth: _____

Email (optional): _____ Phone: ( ) _____

Authorized Recipient (Who May Receive This Information)

Provider Name: _____ Clinic Name: _____

Email: _____ Phone: ( ) _____ Fax: ( ) _____

Information to Be Released

- ☐ Massage therapy treatment records
- ☐ SOAP notes
- ☐ Intake forms / health history
- ☐ Treatment plan
- ☐ Other: _____

Purpose of Release

This information is being released for the purpose of:

- ☐ Coordination of care
- ☐ Insurance / billing
- ☐ Referral
- ☐ Other: _____

Expiration

This authorization will expire **12 months** from the date signed below.

Client Authorization

I understand that I may revoke this authorization in writing at any time, except to the extent that action has already been taken based on it. I voluntarily give permission for the release of the information indicated above.

SAMPLE

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