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Authorization to Release Information

DATE: ______________________

TO: ____________________________________
(healthcare provider/s)

FROM: __________________________________
(Client – please print your name)

All health care information in your possession, whether generated by you or by any other source, may be released to me or to Deb Kimmet Massage & Movement, LLC for the purpose of:

Facilitating my massage therapy and movement education treatment and corrective exercise program
provided by
Deb Kimmet Massage & Movement, LLC

Conversely, I authorize the release of information from Deb Kimmet Massage & Movement, LLC to you for the same purpose.

This release is subject to revocation at any time. The revocation is effective from the time it is communicated to the health care provider. If not revoked, the release terminates when my treatment with Deborah Kimmet Massage & Movement, LLC terminates, or you are no longer treating me, or one (1) year from the date this document is signed, whichever comes first.

Signature: ___________________________________ Date: ______________

I also understand that I am entitled to a copy of this document should I request one.