Consent to Disclose Personal Health Information

(This consent will be reviewed every six months)

I, ______________________________ hereby authorize ______________________________

Patient/Substitute Decision Maker Name Registered *Massage Therapist*

to disclose the following personal health information:

____

____

(Description of personal health information to be disclosed and dates of contact)

to ____

____

(Name and address of person/agency requesting information)

from the records of ______________________________ ______________________

Patient Name *Date of Birth*

Patient Mailing Address: ____

I understand that this personal health information is to be used **only** by the recipient for the purposes of:

____

Date: ______________________________

I hereby waive my right to bring any action or make any complaint or claim against ______________________________, Registered Massage Therapist, in connection with the disclosure of this personal health information.

Witness: ______________________ Signed: ______________________________

Patient/Substitute Decision Maker

Date: ______________________ ______________________________

Relationship to Patient