Medical Information Release Form (HIPAA)

Self Balance Massage
8221 NE Hazel Dell Ave. Suite 103
Vancouver WA 98665
(360) 977-6090

Name: _____ **Birth Date:** ____/____/____

Release of Information

( ) I authorize the release of information including diagnosis, chart notes, imaging records; examination rendered to me and claims information. This information may be released to:

( ) Spouse _____

( ) Children _____

( ) Other _____

_____

( ) Information is not to be released to anyone

This **Release of Information** will remain in effect for one year or until terminated by me in writing.

Messages: Please call

( ) my home: ( ) my work: ( ) my cell number: (_____) _____

If unable to reach me:

( ) you may leave a detailed message

( ) please leave a message asking me to return your call

( ) Other _____

The best time to reach is _____ between (time) _____

Print your name: _____

Signature: _____ Date: ____/____/____