Information Release

Client Initial Here:

- Information regarding my illness/accident/injury can be provided to my physician or other licensed health care provider for purposes of my treatment. _____

- I authorize other healthcare professionals to provide information regarding my illness/accident/injury to Hands on Therapies for purpose of my treatment. _____

- I authorize Hands on Therapies to discuss treatment or scheduling of my appointments with the following family member or designated person: _____

_____
(name and relationship to client)

Signature: _____

Print Name: _____

Date: _____

This authorized release expires 2 years from date of signature

Name of client if a minor or under legal guardianship of signee:

_____
(please print)

All services are provided by
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