CONSENT TO RELEASE INFORMATION

Colette Slone, RMT

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AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

DATE: _____ PATIENT NAME: _____
D.O.B.: _____ CONTACT #: _____

I, _____, authorize the release (disclosure) of my medical records or other healthcare information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information. I authorize my both my massage therapist and the business/clinician listed below to discuss and correspond about my medical status as it pertains to providing me with safe, effective and coordinated massage therapy and payment of said services. I understand that my medical records, in whole or in part, may be used in this process but that any correspondence or discussion will be confined to those medical conditions or treatments, which may be affected by the massage therapy session.

Registered Massage Therapist: Colette Slone, RMT. A8-80 Birmingham St Etobicoke ON M8V 3W6

Business/Clinician: Name: _____

Address: _____

City: _____ Prov: _____ Phone: _____

PURPOSE OF DISCLOSURE

- ☐ Continuing care
- ☐ Legal
- ☐ Insurance
- ☐ Other, Specify: _____

1. I understand that this authorization will expire one year after I have signed the form or _____.

2. I understand that I may revoke this authorization at any time by written notification, and it will be effective on the date received by the therapist except to the extent action has already been taken in reliance upon this authorization.

3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and is no longer be protected by federal privacy regulations.

SIGNATURE OF PATIENT: _____ DATE: _____

Records Released By: _____ DATE:_____