Nick OF TIME
THERAPEUTIC MASSAGE

1105 SW Crestview, Pullman WA 99163 (509) 332-9492

RELEASE OF CONFIDENTAL INFORMATION

I, ____DOB: ___________________

Do hereby authorize *Nick of Time Therapeutic Massage, LLC*

(place your initials on all that apply):

_______ **Release to** and/or _______ **Receive from** the following person or institution, information obtained in confidence from me; **or** I do hereby authorize *Nick of Time Therapeutic Massage, LLC* to _______ **Release to** and/or _______ **Receive from** records pertaining to my child or who is legally in my care as a court appointed guardian (who is 12 years of age or younger): Child's name: ______________________ DOB: _______

health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information

Disclose this information to whom: ____

(Name of Agency) **(Relationship)**

Address: ______________________________ **Phone:** ____________________ **Fax:** _____________________

______________________________ **Email:** ____

This request and authorization applies to:

_______ Health care information relating to the following treatment, condition, or dates of treatment:

____

_______ All health care information:

_______ Other:

____

(Place your initials on all that apply):

The information requested/released is for the purposes of:

__ Evaluation __ Treatment planning __ Coordination of services __ Other ________________

I authorize the receipt or release of medical health records as applicable. I understand that my records are protected under the Federal/State confidentiality regulations and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that my consent is subject to a written revocation by me at any time except to the extent that action has been taken in reliance on it (e.g. court related, probation, parole, etc.) **(Consumer initials _______).**

This release of information is valid for 90 days past the date of discharge from *Nick of Time Therapeutic Massage, LLC or unless otherwise specified below (please specify the date, event, or condition upon which this consent expires)* _______

***Printed Name:* ________________________ *Signature:* ________________________________ *Date*__________**