BODY THERAPEUTICS
MEDICAL MASSAGE
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CONSENT TO RELEASE CONFIDENTIAL INFORMATION

I _____, do hereby consent to and authorize

Body Therapeutics & Medical Massage to obtain from / release to:

_____ _____

(Name of person/facility) (Address)

information pertaining to my identity, diagnosis, prognosis, and/or treatment plan.

This information is needed for the following purposes:

- [X] To provide ongoing assessment and treatment plan.
- [X] To obtain insurance, employment or government benefits.
- [ ] To enable judges, attorneys, probation/parole officers, or health personnel to support treatment goals or make legal decisions on my behalf.
- [ ] To coordinate treatment with my pastor/religious community.
- [X] To coordinate treatment with my family/concerned persons.
- [X] To coordinate between therapists in the agency for the treatment of client.
- [ ] For educational or supervisory review within that confidential framework.
- [ ] Other: _____

I UNDERSTAND THAT BY LAW, I NEED NOT CONSENT TO THE RELEASE OF THIS INFORMATION. HOWEVER, I CHOOSE TO DO SO WILLINGLY AND VOLUNTARILY FOR THE PURPOSE(S) SPECIFIED ABOVE. THIS AUTHORIZATION WILL HAVE A DURATION OF CONSENT NO LONGER THAN ONE YEAR. I UNDERSTAND THAT I MAY REVOKE IT AT ANY TIME EXCEPT TO THE EXTENT THAT ACTION HAS BEEN TAKEN IN RELIANCE ON MY CONSENT.

I UNDERSTAND THAT I AM ENTITLED TO A COPY OF THIS DOCUMENT IN ITS COMPLETED FORM.

_____ _____

(Signature of Patient) (Date)

_____ _____

(Signature of Witness) (Date)