PERMISSION TO SHARE LIMITED HEALTH INFORMATION

Name: ____ Date of Birth: ________________________

By signing this form below, I give permission to the person(s) listed below to receive limited information about my care. I understand that my therapist will use their professional judgment to ensure that the information is shared with my family/friend in order to assist with my continuing care. Any copies of medical records will require a signed HIPAA compliant authorization. This permission will be considered ongoing until I state otherwise in writing.

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Name: ____

Relationship: ____

Comments/Instructions: ____

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Client/Guardian Initials: __________________________

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Name: ____

Relationship: ____

Comments/Instructions: ____

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Client/Guardian Initials: __________________________

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Under no circumstance can Fusion Bodywork release medical/bodywork/confidential information obtained from your physician or provider of service to you or anyone unless previous consent has been provided.

Client/Guardian Signature: ____ Date: ___________________