Therapy Designed For You

Authorization to Disclose
Personal Health Information

82 Palomino Lane, Suite 501
Bedford, NH 03110
603-627-6381

Note: Please complete one Authorization to Disclose form for each medical office to be contacted.

Patient Name: _____

Date of Birth: _____

Medical/Oncology Office Name: _____

Person/Department Contact: _____

Address: _____

City: _____ State: _____ Zip _____

Telephone: _____ Fax: _____

I authorize (a) the release of any requested medical information related to and (b) discussion of my oncology history and ongoing treatment with Therapy Designed for You licensed massage therapists in relation to providing me with therapeutic massage treatment.

This release is valid until revoked in writing.

Patient Signature: _____

Dated: _____