MASSAGE SOLUTIONS
of Bend

HIPPA & Medical Release Form

Name ______________________________ Date of Birth ______/______/______

RELEASE INFORMATION

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

- ☐ Spouse ______________________________
- ☐ Child(ren) ______________________________
- ☐ Other ______________________________

- ☐ Information is not to be released to anyone.

MESSAGES

Please call: ☐ cell phone ☐ work or ☐ home phone ______________________
If unable to reach me:

- ☐ you may leave a detailed message
- ☐ please leave message asking me to return your call
- ☐ The best time to reach me is [day] ____________ between (time) ________

AUTHORIZATION TO DISCLOSE MEDICAL RECORDS

I ______________________________ authorize Massage Solutions of Bend, LLC to release a copy of the medical information for my treatments to
______________________________________ .

This information will be used on my behalf for medical treatment and billing information only.

Date: ____________ Signature: ______________________________