Kathy Doerfer, BSN, Licensed Massage Therapist
224 E. Court St., Viroqua, WI 54665
kathy.doerfer@viroquahealingarts.com
608-637-7600 ext. 24

Authorization to Release Medical Information

Client Name: ____ Date of Birth:______________

Address:______________________ City________________ State: _____ Zip Code: ________

Telephone Number: _______________________

Contact Person (if other than client): ___________________________ Phone: ______________

I: ________________________________ authorize communication of my medical records and

health care information by and between Kathy Doerfer, LMT and the health care provider named below.

Name: ____ _____

Address: ____ ___

This authorization is limited to records and information relevant to my receipt of massage therapy.

I give my authorization to release health care information for the following purposes (check all that apply):

___ To share information with my health care team in an attempt to coordinate care.

___ To obtain payment of care expenses I have incurred for my treatments.

___ Other:
____
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I understand that this authorization may be revoked at anytime by writing a letter to Kathy Doerfer. This authorization will expire one year from the date below.

Signature: ____ Date:
____