Massage By Carey
Medical Records Release

_____ Phone _____
Client Name

_____ Patient ID _____
Date of Birth

I, _____, (print name) authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of, _____ to _____; to be sent to the following person or company.

☐ Massage By Carey
1503 Bridal Path Cove
Cedar Park, TX 78613
Tel (512) 983-9943
Email carey@massagebycarey.com

☐ Other: Fill out below

_____
Provider/Company

_____
Address, City, State, Zip

_____ _____
Telephone Fax

_____
Email

Client Signature _____ Date _____