Balance Integrative Care

*Illness and Pain Management through Mind and Body*

# Authorization to Release Information

I, _____, (hereinafter "Client") hereby authorize Balance Integrative Care, PLLC (hereinafter "Therapist") to disclose health information and records obtained in the course of psychotherapy and massage therapy treatment of Client to:

_____

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Therapist has taken action in reliance upon it. And, I also understand that such revocation must be in writing and received by Therapist to be effective.

This disclosure of information and records authorized by Client is required for the following purpose:

_____

The specific uses and limitations of the types of medical information to be discussed are as follows:

_____

Such disclosure shall be limited to the following specific types of information:

_____

_____

Therapist shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form.

Client understands that information used or disclosed pursuant to this authorization should not be subject to re-disclosure by the recipient.

This authorization shall remain valid until: _____

Client's signature:_____ Date:_____