1053 Fond du Lac Ave.
Kewaskum, WI 53040
(262) 477-1555

Authorization to Release Medical Records

Patient Name ____ Date of Birth ________________________

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above named patient.

PATIENT INFORMATION IS NEEDED FOR:

____

Specific case information may include report of findings, SOAP notes, health questionnaires, treatments plans, and medical history.

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address and contact information):

TO:

____

____

____

FROM:
LORI E. BERSCH, LMT
INTEGRATIVE ORTHOPEDIC MASSAGE, LLC
1053 FOND DU LAC AVE., KEWASKUM, WI 53040

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization in writing prior to that time.

Printed Name of Patient or Legally Authorized Representative

____ **Date:** ______________________

Signature of Patient or Legally Authorized Representative

____ **Date:** ______________________