

Massage Record and Health History Release Form

By signing this form I, _____, authorize Emma Lani Massage Therapy to release confidential health information about me and the massage sessions I receive to the following:

Recipient of Records:

___ Patient requesting records

___ Other party

Full Name of Recipient: _____

Address: _____

City, State, and Zip Code: _____

Email: _____

Phone: _____

Purpose for Release of Information:

Effective Date of Authorization:

This authorization is effective through ____/____/____ or until I cancel this consent. I understand that I may revoke or terminate this authorization by submitting a request in writing to Emma Lani Massage Therapy at 37 Juliette Dr. Durham NC, 27713

Client Name (print): _____

Client Signature: _____ Date: _____

Date of record release: _____

Therapist Signature: _____