Mutual Medical Information Release Authorization (MMIRA) Termination 2023

Patient/Client Name: _____ DOB: _____

Address: _____

I, _____, hereby terminate the release of any and all pertinent health and
Patient/Client Name

medical information between . _____ and Schnipke Massage to Health, LLC
Physician Massage Therapist

pertaining to the overall health and wellness of myself, their mutual patient/client, between each other.

Please initial each to verify that by signing this authorization you understand:

_____ I have the right to receive a copy of this MMIRA termination.

_____ I understand I will receive 1 copy for my physician and 1 for my records immediately after signing.

_____ I understand a copy of this MMIRA termination must be delivered to my physician by me.

_____ I revoke the authorization to disclose my identifiable health information as described above.

_____ This letter serves as my written termination of my previously signed MMIRA and any person to whom my medical information was disclosed pursuant to that authorization may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is required by law.

Patient Signature_____ Date_____