Mutual Medical Information Release Authorization (MMIRA) 2023

Patient/Client Name: _____ DOB: _____

Address: _____

I, _____, hereby authorize _____ and
Patient/Client Name Physician
__Schnipke Massage to Health, LLC__ to release any and all pertinent health and medical information
Massage Therapist

pertaining to the overall health and wellness of myself, their mutual patient/client, between each other. This release of information will remain in effect until terminated by myself in writing.

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

_____ I understand I am not required to complete this form as part of my new client packet unless I believe it is deemed medically necessary.

_____ I understand that by signing this authorization I am doing so voluntarily and the massage therapist may still deny service if they believe the risk is too great to the client.

_____ I have the right to receive a copy of this authorization

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

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

_____ I authorize the disclosure of my identifiable health information as described above.

_____ I have the right to terminate this authorization and revoke permission to release information. The revocation must be made in writing and will not affect information that has already been disclosed.

_____ I understand that the person to whom my medical information is disclosed pursuant to this 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_____