**RELEASE OF INFORMATION**

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**RELEASE OF INFORMATION STATEMENT**

I authorize the release of information between my physician, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and massage therapist, Mary Ann Konarzewski for the purpose of planning safe and effective massage therapy sessions. I understand that my medical records may be used in whole or part, but that only medical information relevant to massage therapy will be released.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_