Susan C. Jackson & Associates
Massage Therapy Clinic

Authorization for Release of Complete File Information

I, _____, or my Guardian or appointed representative, hereby authorize ***Susan C. Jackson & Associates Massage Therapy Clinic*** to release by mail or facsimile, consultation summaries in the form of written initial assessment reports, progress reports, daily notes, discharge summaries, and/or communicate directly to my family physician, insurance company or referring source.

I also authorize ***Susan C. Jackson & Associates Massage Therapy Clinic*** to obtain from my family physician, specialist, health care provider or their consultants, medical information which may be pertinent to the treatment of my condition by ***Susan C. Jackson & Associates Massage Therapy Clinc.***

DATE:_____

Client Signature:_____

Therapist: _____