Sync – Myofascial & Massage Healing Therapies Holly Holm, LMT

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client Name:	Date of Birth:
Address:	Home phone:
	Work or Cell:

I request and authorize **Sync Healing Therapies - Holly Holm, LMT** to release healthcare information of the client named above to:

Name:	
Address:	Phone:
	Fax:

This request and authorization applies to:

Healthcare information and records relating to the following treatment, condition, or dates:

_____
_____
_____
_____
_____

Patient Signature: _____ **Date:** _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.