Cindy Thomas, LMT LLC

402 S. Main Street, Rock Port, MO 64482
Phone: 660-787-0182

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Client's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize *Cindy Thomas, LMT* to release healthcare information of the client named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

_____ _____ _____

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

☐ Parent/Guardian signing for child under 18 years of age. Relationship to client:_____

Client Signature: _____ Date Signed: _____

Client Signature: _____ Date Signed: _____

Client Signature: _____ Date Signed: _____

Client Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.