Medical Records Release Form

Client Name: _____________________________________

Address: ____

City: ____

State: Province: Country: ____________________________

Zip/Postal Code: ________

Telephone:_________________ Email: ____

Date of Birth: _____________ Social Security Number: _____________________________

I authorize the release of my medical records or other health care information, including intake forms, chart notes, reports, correspondence, billing statements, and other written information concerning my health and treatment during the period of: ____

to be sent to the following person or company:

Elements Of Life Wellness LLC

André Cross LMT CNMT GA# MT005971

2751 Buford Hwy NE Suite 700

Atlanta, GA 30324

470-449-3449

AndreTouch1@MassageTherapy.com

HTTPS://AndreTouch1.MassageTherapy.com

Client Signature: ____

Date: ___________________

This authorization is valid until: _______________________