

Advanced Motion Therapeutic Massage, Inc.
Record Release Authorization

Patient Name: _____

Organization: _____

Address: _____

Phone Number: _____

I hereby authorize Advanced Motion Therapeutic Massage Inc. to obtain the following information from the organization listed above.

Patient Signature

Date

Patient Name (Please Print)

If Patient is a Minor Signature of Parent or
Legal Guardian

Relationship to Patient

(Photo Copy will be accepted as original. This release is in effect for 1 year from date signed.)