AMERICAN MEDICAL MASSAGE NETWORK (AMMN)

MEDICAL INFORMATION RELEASE FORM

TO WHOM IT MAY CONCERN

Print Name:_____Date of Birth:_____

Address:_____City:_____State:____Zip:_____

Home Tel:_____Cel:_____Email:_____

I hereby authorize the release of the following health information:

☐ Complete Medical Record ☐ Immunization Record ☐ Physicals ☐ Diagnostic Tests/Lab Reports

☐ Other:_____

☐ **Period from**:_____to_____

The following information will not be released with your signature on the list next to it.

☐ Mental Health (including ADHD/ADD)_____☐ Alcohol/Drug Information:_____

☐ Sexually Transmitted Diseases/Testing:_____ ☐ HIV Testing & Results:_____

☐ Pregnancy_____☐ Abortion:_____☐ Sexual Assault:_____

Reason for Request: ☐ Medical Massage:_____

Comments:_____

_____

☐ Record to be sent to:

Health Care Provider/Facility:_____

_____

☐ Records to be received from:

Health Care Provider/Facility:_____

_____

Person Completing form (Print Name):_____ Relationship:_____

Signature:_____ Date:_____