Client Release of Information Form

Request made to:

Re-Member Massage
Nanci Williams, LMT 14787
1675 SW Marlow Ave #307D
Portland, OR 97225
503-939-9123

I authorize the release of my medical records or other healthcare information; including intake forms, chart notes, reports, correspondence, billing statements, and other written information to the following person or business:

Name of business/clinician: _____
Address: _____
_____
_____
Telephone/Fax: _____
E-mail: _____

Client signature: _____
Date: _____

Client name: _____
Date of Birth: _____

If this authorization should cover more than a single release of information or children/dependents, please specify dates below and write the names next to your signature:

Authorization is valid until: _____ (date)