Body In Motion
Massage Therapy, LLC

Authorization for Disclosure of Medical Information

Patient Name: _____ DOB: _____

Street Address: _____

City, State, Zip code: _____

Phone Number: _____

I Authorize: Name of Practitioner or Clinic: _____
(Provider of Information)

Phone Number: _____ Fax Number: _____

Street Address: _____

City, State, Zip code: _____

to release the following records to Susan Stokman, LMP at Body In Motion Massage Therapy:

( ) Office Visit Chart Notes

( ) Laboratory/Diagnostic Reports

( ) Imaging, X-Rays, or MRI Results

( ) All Medical Records From the Past ____ Years

I understand this authorization may be revoked in writing at any time. Unless revoked earlier, this authorization will expire in 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

Patient/Legal Guardian Signature: _____ Date: _____

Printed Name: _____

Please Fax or Email Records to:

Susan Stokman, LMT, MMP
1703 Main Street; Suite B | Vancouver, WA 98663
Fax: 360-718-8593 | Email: susan@bimmt.com
Phone: 360-718-8613