HANDS ON HEALING

AUTHORIZATION TO RELEASE INFORMATION

I,_____ _____
(PRINT NAME OF PATIENT) (DATE OF BIRTH)

authorize John Leonard, PT, LMBT and Hands-On Healing, LLC to receive, provide, and/or request the release of any protected health information regarding my treatment, payment, or administrative operations related to treatment by John Leonard, PT, LMBT.

Specific test or information: _____.

Name of person/business to provide and/or receive the information:
_____.

Patient's signature: _____

If person has a guardian:

_____ _____
(PRINT NAME OF GUARDIAN) *(SIGNATURE OF GUARDIAN)*

Date: _____

_____

Granting the same permission to these additional persons/businesses:

**Specific test or information: _____.

**Name of person/business to provide and/or receive the information:
_____.

Patient's signature: _____

If person has a guardian:

_____ _____
(PRINT NAME OF GUARDIAN) *(SIGNATURE OF GUARDIAN)*