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Allowing Us To Share Information

This is written permission for the office of P. Leilani Berry, Licensed Massage Practitioner to use and share my personal medical information and records for the purposes of billing, checking my insurance benefits, corresponding with my other treating physicians and my attorney [if applicable], and for getting referrals for massage treatment. This authorization will end in one year from the date below.

Patient Name: _____

Insurance Company Name: _____

Referring Physician Name: _____

My Attorney [if I have one]:_____

I am giving my permission willingly and I know I can refuse to sign this authorization. I understand I can withdraw or take back this permission at any time. I also acknowledge having read and received "Your Privacy and Your Rights" policies and guidelines.

_____ _____

Signature of Patient or Adult in case of Minor Date