RELEASE OF INFORMATION

I authorize Bethany Bachmann LLC, L.M.T., C.C.S.T. to release information regarding my treatment, to my physician, health care practitioner or mental health counselor, as listed below, for the purposes of continuity of care, and follow-up.

I understand that this release is valid when I agree to it. I further understand that I may withdraw my consent to this release at any time either orally or in writing to Bethany Bachmann LLC, and that this consent is given of my own free will.

I understand that after this information is disclosed, federal law might not protect it, and the recipient might redisclose it. A photocopy of this signed authorization form shall be considered as valid as the original signed copy.

Physician:_____

Health Care Practitioner:_____

Mental Health Counselor:_____

Signature:_____Date:_____

Printed Name:_____

Bethany Bachmann LLC
Certified Craniosacral Therapist
Licensed Massage Therapist
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