Boulder Therapeutics, Inc.
303-444-1171
www.bouldertherapeutics.com
Boulder ♦ Broomfield

Authorization to Release Health Information

I, _____ (client), authorize my Physician, _____, and my Massage Therapists at Boulder Therapeutics, Inc., to discuss and correspond about my medical status as it pertains to providing me with safe and effective massage therapy.

I also authorize the following people to discuss and correspond about my medical status under the conditions listed here (if any). Please include phone numbers:
_____
_____
_____
_____
_____
_____

I understand that my medical records, in whole or part, will be used in this process, but that any correspondence or discussion will be confined to those medical conditions or treatments which may be affected by the massage therapy session.

I wish to exclude the release of the items and information listed here:
_____
_____
_____
_____

Signature:_____

Date:_____