## RELEASE OF INFORMATION

I hereby authorize:	To release to:
	Name
Vicki Walther, LMT, CMT, BCTM  Massage Therapist  Phone 262-224-5679	Address
	City         StateZIP           Phone
The Confidential Records for:	
Printed Patient's Name:	······································
Patient address:	
Date of Birth:	Phone:
This request and authorization app	olies to:
□ Health care information relating to the following condition or treatment (provide details)	
	toOR number of visits to be included
	age therapist, and its employees from any legal responsibility ve information to the extent indicated and authorized above.
Signature	Date
TTI ' 1 1	

This release may be rescinded at any time by providing notice in writing.