N Balance Medical Massage
T H E R A P Y

# AUTHORIZATION TO OBTAIN MEDICAL INFORMATION

**Patient Name (printed)_____ DOB_____**

I authorize any physician, dentist, chiropractor, hospital, pharmacist, medical professional, health care provider, insurance company, worker compensation provider, or employer to disclose all information about past and present medical care, history, physical condition, and injuries including itemized statements to N Balance Medical Massage Therapy LLC.

I agree that this authorization will remain valid up to one year of the signed date, unless revoked by delivery of written notice to N Balance Medical Massage Therapy LLC.

I hereby designate the above named company and its claims personnel as my designated representative, pursuant to NCGS Sec 90-411 for the purpose of obtaining copies of my medical records, the production of which is authorized herein. It is specifically my intent that this designation provide to the company named above the benefit of the maximum fees established in NCGS Sec 90.41.

I understand that I (or my representative) am entitled to receive a copy of this authorization. A photocopy of this form may be accepted as the original.

I (or the patient named above) have received health care treatment from the following providers:

_____ _____
Provider Name Phone

_____ _____
Provider Name Phone

_____ _____
Provider Name Phone

Requesting: □ Entire File □ Diagnostic Tests
□ Progress Notes □ Related to MVA on _____

Please send records to:

**N Balance Medical Massage Therapy LLC.**
**2911 N Tenaya Way #215**
**Las Vegas, NV 89128**

**Phone # (702) 274-0054**
**Email: info@medicalmassagelv.com**

_____ _____
**Signature of Patient** or Person Authorized to Act on Patient's Behalf **Date**