

**CONSENT FOR RELEASE OR TRANSFER OF
CONFIDENTIAL HEALTH CARE INFORMATION**

To: Health Care Provider, Health Care Facility, Insurance Company or Health Care Professional

You are hereby requested and authorized to release to Infinity Massage and/or its authorized representatives, including any physician or attorney retained by it, copies of any and all hospital, medical, vocational and other records to injuries sustained in an automobile accident on _____.

Furthermore, if determined necessary, I hereby give permission to Infinity Massage to share the information received with other health care professionals for the purpose of performing a medical/bill review, independent medical examination, peer review, nurse consultation, and/or vocational/rehabilitation review.

A copy of this authorization may be accepted with the same authority as the original.

Client

Date