The Healing Joint

Jeanette Musset, NMD

I consent to the injection procedure. I have been informed of the possibility of complications as detailed above, and am happy to accept this. I agree to not hold Dr. Jeannette Musset, responsible.

AUTHORIZATION FOR RELEASE OF RECORDS

IF MORE THAN 5 PAGES PLEASE MAIL UNLESS OTHERWISE REQUESTED

I,___________________________________ Birthdate:________________

Address:_____________________________ Phone:___________________

Authorize:_____________________________________

Address:______________________________________

Phone/Fax:____________________________________

I authorize release of my medical records including confidential and/or communicable disease-related information, including HIV/AIDS information.

Please release the following information:

____All Medical Records

____Labs Only All or provide date of service___________

____Send only:____

Release to:____________________________________

Address:______________________________________

Phone/Fax:____________________________________

If you are requesting your records to be released to yourself or another physician, are you dissatisfied with our office for any reason?

____ ________

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____ ________

Patient Signature:________________________________ Date:__________

Effective Date:___________________ Expiration Date:_______________

Completed By:________________________ Date:_____________________