

# Progressive Laser LLC



"Science enhancing Beauty..."

## Massage Authorization to Share

In order to comply with federal regulations regarding your privacy in our office, we ask that you complete the following questions:

Patient name \_\_\_\_\_ DOB \_\_\_\_\_

### Leave appointment and billing messages on/with:

Answering Machine?            \_\_\_ Yes \_\_\_ No  
Office Voice Mail?            \_\_\_ Yes \_\_\_ No  
With another Person?        \_\_\_ Yes \_\_\_ No  
Sent through the mail?        \_\_\_ Yes \_\_\_ No  
Send via email?                \_\_\_ Yes \_\_\_ No  
Cell Phone?                     \_\_\_ Yes \_\_\_ No

If you answered YES to allowing us to discuss your appointment or billing information with another person, please list their names(s), relationship(s) and phone # below:

Name:	Relationship:	Phone:	Cell Phone:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PATIENT OR LEGAL REPRESENTATIVE SIGNATURE:

\_\_\_\_\_

IF LEGAL REPRESENTATIVE, INDICATE RELATIONSHIP:

\_\_\_\_\_

DATE: \_\_\_\_\_