By the office of P. Leilani Berry, LMT
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Sharing Information Permission

This is written permission for the office of P. Leilani Berry, LMT to use and share my personal medical information and records for the purposes of billing and corresponding with my other treating medical providers and my attorney (if applicable.) This authorization will end in one year from the date below.

Patient Name ____
(Print)

Insurance Company ____

Medical Provider ____

Attorney (if you have one) ____

I am giving my permission to willingly and I know I can refuse to sign this authorization. I understand I can withdraw or take back this permission at any time. I acknowledge having read and received "Your Privacy and Your Rights" policies and guidelines.

Signature ____

Date ____