



Living Intuitive Resources

AUTHORIZATION TO RELEASE/DISCUSS MEDICAL/CARE INFORMATION

CLIENT:

I hereby authorize Teresa Robertson RN,CNM,MSN, to release and/or discuss information regarding my treatment/medical care with her, with my other care providers.

I hereby hold harmless, Teresa Robertson RN,CNM,MSN, Birth Intuitive, and any of her employees and associates for any and all results which may occur due to the release and/or discussion of my medical care/treatment with my other health care providers.

DATE_____

CLIENT SIGNATURE_____

WITNESS SIGNATURE_____

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