Holistic Personal Training Services
Move better….Live better.™

AUTHORIZATION FOR COLLABORATION WITH ALLIED HEALTH PROFESSIONAL

TO_____

Doctor/practitioner/Facility

ADDRESS_____

I hereby authorize and request you to disclose and discuss any and all pertinent health information for the purposes of collaboration, in the best interest of my health and welfare, to:

Jennifer L. Armstrong
Armstrong Integrative Movement, LLC
1977 Hendersonville Rd., Suite 3
Asheville, NC 28803

SIGNATURE_____

DATE_____

Client

PRINTED_____

Client

_____ _____

WITNESS **RELATIONSHIP**