



RELEASE OF CLIENT INFORMATION AND NOTICES

By signing this document, I am authorizing Thermal Imaging Services to communicate my Physician's Insight Thermography Report to either my home address or another address listed below. **I understand that any information on file will not be released to any outside 3rd party without my prior written permission. I also understand that I will receive one report and extra paper copies of my report are an additional \$5.00.**

_____ Please send report to my designated address on file.

Client Signature or Responsible Party

Date

Additional reports to be sent to:

Name of party to receive report

Address or email address

Kathy Markham, CCT

Date

A photocopy of this document shall be considered as effective and valid as the original.

*Thermal Imaging Services – 9639 Hillcroft PMB #905 – Houston, TX 77096
713-621-4406 (office) – 713-988-2003 (fax)*