



*Excellence in Pain Relief  
& Women's Health*

Premier Acupuncture & Complementary Medicine, Inc.  
6177 E Mountain Heather Way Suite 5  
Palmer AK 99645  
907.745.7928

### **RELEASE FOR TESTING**

Infrared Imaging is a non-contact, non-invasive test that demonstrates physiological patterns of your body. It is not a stand-alone diagnostic test. The information provided by your thermal scan is combined with your history to enable your health care provider to plan an approach to your care.

A licensed medical practitioner is the only qualified person to formulate a diagnosis. He or she must combine thermographic studies with your additional clinical and testing information to determine whether a problem or potential problem exists.

Infrared scans provide evidence of thermal asymmetries that may be present. An asymmetry may be indicative of a vascular, neurological, muscular or other physiological problem including cancer.

I have read the above information and I understand that I am not receiving a diagnosis of any condition based solely on my thermal scan. I understand that a thermal scan is non-invasive, and is reading the thermal patterns on the surface of my body. From this information a qualified practitioner will interpret any thermal abnormality displayed.

I am aware that my insurance provider may not reimburse me for the cost of this test. I understand that I am required to pay for this exam at the time of testing.

**Print and sign your legal name:**

\_\_\_\_\_ Date: \_\_\_\_\_

### **RECORD RELEASE**

I, (signature) \_\_\_\_\_ authorize this clinic to release information regarding my scans, or to send copies of my scans to the following physicians. Please provide address or phone number.

1)

2)

### **MAIL RELEASE**

I am aware that my thermography images and report may be mailed at my request to my address, or to my doctor's address, and that mail is sometimes lost or could be misdirected or stolen. Even though it is marked confidential, it could end up in unauthorized hands.

I, (signature) \_\_\_\_\_ authorize my thermography report and images to be mailed to my address, or to my doctor's address.