

AUTHORIZATION TO RELEASE MEDICAL RECORDS

DOCTOR/HOSPITAL: _____

ADDRESS: _____

I HEREBY AUTHORIZE AND REQUEST THE RELEASE OF MY MEDICAL RECORD TO:

SOUTH FLORIDA PHYSICAL THERAPY ASSOCIATES

THANK YOU IN ADVANCE FOR YOUR COOPERATION.

PATIENT'S SIGNATURE DATE

PRINT PATIENT'S NAME DATE OF BIRTH SOCIAL SECURITY #

IF PATIENT IS A MINOR SIGNATURE OF PARENT OF LEGAL GUARDIAN RELATIONSHIP TO PATIENT

WITNESS TO THE ABOVE SIGNATURES PLEASE PRINT NAME