



Authorization for Release of Information

I hereby authorize _____

to release my medical records to Alpine Physical Therapy. Information is being requested at this time as follows:

(Please check all that apply)

- _____ Please release my entire chart
- _____ Operative report dated _____
- _____ X-ray report dated _____
- _____ History and physical _____
- _____ Discharge summary dated _____
- _____ Physical therapy notes dated _____
- _____ Other _____

I hereby consent to the release of the above information for the purpose of formulating an appropriate physical therapy plan at the Alpine Physical Therapy clinic.

A photocopy/fax of this document shall be considered as valid as the original. This release shall be in effect until revoked.

Name (Please print) _____

Birth date _____

SSN _____

Signature of client/guardian

Date