CENTRAL PHYSICAL THERAPY MEDICAL RELEASE FORM

Date: _____

Patient Name: _____

Date of Birth: _____

To Whom It May Concern:

I HEREBY GIVE BACK TO CENTRAL PHYSICAL THERAPY, LLC PERMISSION TO RELEASE THE FOLLOWING MEDICAL INFORMATION/ RECORDS & REPORTS PERTAINING TO

Patient Name: _____

(Injury site) _____

(Subject matter to be discussed)_____

_____

Patient Signature: _____

Thank You!