Central Physical Therapy Consent for Release of Information

Patient Name _____

Address _____

Phone Number _____ Date of Birth _____

I hereby authorize Central Physical Therapy to release information **including the diagnosis, records, examination rendered to me and claims information** to the following persons:

Name _____ Phone Number _____

Address _____

Email _____ Relationship _____

Name _____ Phone Number _____

Address _____

Email _____ Relationship _____

I authorize Central Physical Therapy to release information for **emergency purposes only** to the following persons:

Name _____ Phone Number _____

Address _____

Email _____ Relationship _____

Name _____ Phone Number _____

Address _____

Email _____ Relationship _____

Name of Patient or Guardian _____ Date _____

Signature of Parent or Guardian _____

This Release of Information will remain in effect until terminated by me in writing.