AUTHORIZATION TO RELEASE MEDICAL RECORDS

I, ___________________________________, hereby authorize *Advantage Physical Therapy and Rehabilitation,*
Patient or Legal Representative
LLC, its therapists, employees, and agents to release medical records and information pertaining to any medical history, mental or physical condition, or treatment and services rendered to:

*Patient's Name:		Social Security No:	
*Date of Birth:		Medical Record No:	
*Sex		Date(s) of Service:	

**Required Information*

Such disclosure shall be limited to the following medical records, specific type of information, or dates of treatment:

Specific Medical Condition(s): ____

And/or Specific Timeframe(s): ____

Type of Records Needed:

☐ **Complete Medical Record**

☐ Only the records specified above

If not being picked up from the clinic, Records are to be sent to:

Name:				Phone:	
Address:					
City:		State:		ZIP:	

I understand that this authorization shall become effective immediately and shall remain in effect for one year from the date of signature. I understand that I may change or revoke this authorization at any time by notifying *Advantage Physical Therapy and Rehabilitation, LLC* **IN WRITING**.

Signature: ____ Date: ________________

If signed by other than the patient, indicate relationship: ____