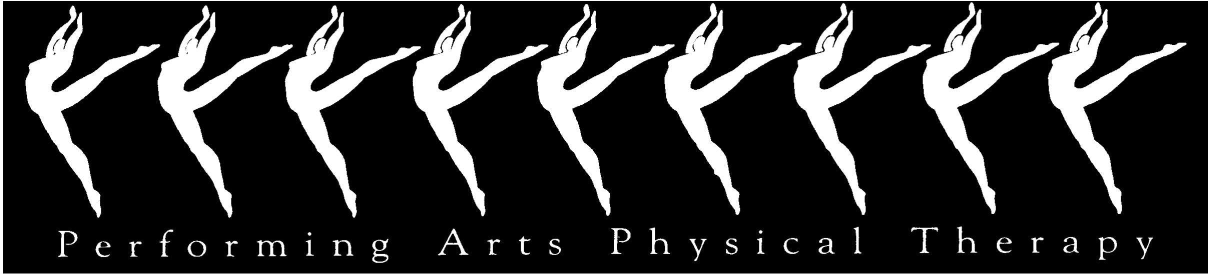

GENERAL RELEASE OF MEDICAL INFORMATION

I, ______________________________________

____
(PATIENT NAME)

(ADDRESS)____

D.O.B__________________

HEREBY AUTHORIZE PERFORMING ARTS PHYSICAL THERAPY, P.C., TO RELEASE

INFORMATION RELATED TO MY TREATMENT FROM

(Specify Date) _________________

MY ENTIRE TREATMENT FILE TO THE FOLLOWING:

CHECK ALL THAT APPLY:

1.________

MY TREATING PHYSICAN:____

ADDRESS____

2. _______ MY INSURANCE COMPANY:

(NAME)____

(ADDRESS, TELEPHONE OR FAX #)

____

(POLICY #) _________________________________

3. _________ OTHER:

(RELATIONSHIP) ____________________________________

(NAME) ____

(ADDRESS, TELEPHONE OR FAX #) ____
_