Patriot All Pro
PHYSICAL THERAPY CENTERS

CONSENT FOR RELEASE OF INFORMATION

Patient'sName:_____

(Last) (First) (Middle Initial)

Patient's Last Name if Different During Treatment: _____

Date of Birth: _____/_____/_____

(Month) (Day) (Year)

Current Address: _____

(Street Address)

_____, _____ _____

(City) (State) (Zip)

This information is to be released to: _____

For the purpose of: _____

I hereby **AUTHORIZE** and **DIRECT Patriot All Pro Physical Therapy Centers** to release any and all information from the medical records of the udersigned, including but not limited to any billing statement and treatment notes and/or medical evaluations.

_____ _____

(Patient's Signature) (Date)

Corporate Office
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