Consent to Release Medical Information

To: _____

I, _____, hereby give my permission for Alliance Physical Therapy (provider) to receive my records/ radiographs including the dates of treatment from _____ to _____- specifically all information you may have regarding my condition when under your observation or treatment, including history, findings, diagnosis, all radiographs and subsequent of further development.

_____
_____
_____
_____
_____

In the event that I wish to revoke the authorization in the future, I will submit in writing my desire to do so to Alliance Physical Therapy.

Print Name: _____ Date: _____

Signature: _____ Date of Birth: _____

Witness: _____ Social Security #: _____