



## NAT'L MEDICAL REHABILITATION

9400 LIVINGSTON ROAD, SUITE 450 FORT WASHINGTON, MD 20744  
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Physical Medicine & Rehabilitation • Physical Therapy

### **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

#### *To Nat'l Medical Rehabilitation*

PATIENT NAME: \_\_\_\_\_

PATIENT IDENTIFIER: (Date of Birth): \_\_\_\_\_

ADDRESS: \_\_\_\_\_

This authorization, or photocopy hereof, will permit **NAT'L MEDICAL REHABILITATION** located at **9400 Livingston Road, Suite 450, Fort Washington, Maryland, 20744**, and its representative, to request, review and/or make copies including photocopies of ***any and all medical records*** concerning the injuries or illness resulting from the accident or injury or illness on: \_\_\_\_\_.

(DATE OF INJURY OR INJURY DESCRIPTION)

This authorization will permit the above action with reference to all medical reports, x-rays, charts, records and other data in possession or control of you relative to the physical condition, treatment and care rendered to the above-named as result of said occurrence.

PATIENT'S SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_

Parent/Guardian/Personal Representative Signature: \_\_\_\_\_

Name/Title of Authorized Signer: \_\_\_\_\_