**PATIENT INFORMATION RELEASE**

PATIENT NAME (LAST, FIRST, MIDDLE)

BIRTHDATE                                            TELEPHONE                                                               ALTERNATE PHONE

STREET ADDRESS

CITY                                                                   STATE                             ZIP CODE EMAIL:

GENDER: PREFERRED PRONOUNS (OPTIONAL)

**PROVIDER: A BETTER WAY PHYSICAL THERAPY LLC**

Type of information to be released (Please be Specific) for the PLAN OF CARE and extensions for this episode:

PT EVALUATION: NOTES AND BILLS

**REQUESTOR (**Name/s of people with Whom I can share information **if any IE:** Spouse, children, parents, Attorneys**) DO NOT INCLUDE INSURER OR REFERRING DOCTOR.**

**INFORMATION LIMITATIONS**

*List any restrictions of information to be released:*

I give permission to the PROVIDER to release Medical Record Information to the REQUESTOR concerning the MEDICAL CONDITION/INJURY described above which was diagnosed/treated during the stated TIME PERIOD. The  information released will be restricted by any INFORMATION  LIMITATIONS outlined above, and may be used only for the purpose described.

I understand that I can cancel this release at any time by notifying the PROVIDER in writing and that my cancellation will take effect when the PROVIDER receives my written notice. I understand that my

cancellation will not have any effect on information released before the PROVIDER received my written notice.

Signature of Person Releasing Information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Person Releasing Information (Please Print):

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_