

PTcares Physiotherapy and Wellness LLC

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All other healthcare information

☐ Other: _____

Patient Signature: _____

Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED