VERNON PHYSICAL THERAPY

RELEASE OF RECORDS FORM

Today's Date: :_____/_____/_____

To whom it may concern

By my signature below, I hereby authorize release of my medical records to VPT - Vernon Physical Therapy.

Patient Name:_____Date of Birth:_____/_____/_____

Records related to:_____

_____

_____

Patient's Signature:_____

Please fax records to:

VPT | Vernon Physical Therapy
Fax (303) 867-2082

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info@vernonpt.com ► www.VernonPT.com