RECORDS RELEASE FORM

I _____ authorize **The Center for Physical Health**
Patient Name

to release my medical record to be sent to the specific individual or Physical Therapy practice listed below. Please include the name and address of recipient.

Recipient Name: _____

Recipient Address: _____

Recipient Phone or Fax: _____

I release The Center for Physical Health from any laws related to disclosure of confidential or privileged information.

Signature _____ Date _____

There is a $25 charge for administrative cost of copying and mailing these medical records to the recipient if you want them sent directly to a different Physical Therapy Office then there will be no charge. You can pay by cash, check or credit card. Checks should be payable to **The Center for Physical Health** or you can provide your credit card information below. When we receive the authorization form, we will process the request as quickly as possible.

Credit Card #: _____

Billing Zip Code: _____

Expiration Date: _____

CVC/CVV #: _____

Print Name on Card: _____

Signature of Cardholder: _____