Medical Records Release
(Please Print Clearly)

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient Information			
Last Name:	First	Middle	Date of Birth / /

I request and authorize Encore Physical Therapy, PLLC to release health care information of the patient named above to ____________________________________.
Phone Number: ( ) ________________
Fax Number: ( ) ____________________

This request and authorization applies to:

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

☐ All healthcare information

☐ Other: ____

I understand that my records are protected by state and federal laws and cannot be disclosed without my written consent unless otherwise provided for in the state and federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken on it.

X____
Patient/Guardian Signature Date