EVOLVE Physical Therapy

8499 Hwy 42
Fish Creek, WI. 54212
Ph: (920) 421-4600
Fax: (920) 345-7159

AUTHORIZATION and/or REQUEST for MEDICAL RECORDS RELEASE

Patient Name: _____ Date of Birth: _____/_____/_____

Authorize & Request

Name of Party to release records: _____

Address: _____

Phone #: _____

Please release the following records:
(Purpose of disclosure is Physical Therapist request/treatment)

____ Medical Records
____ MD Office Notes
____ Imaging Reports
____ Other: _____

Expiration:
This authorization will expire one year from the date of signature (if no date specified) or the chosen date of _____/_____/_____.

Recipient of released records:
Evolve Physical Therapy
8499 Hwy 42
Fish Creek, WI. 54212
Phone: (920) 421-4600
Fax: (920) 345-7159

X Patient/Parent/Guardian Signature: _____
Relationship to Patient: _____ Date: _____/_____/_____

This authorization shall be valid for procurement of records and reports of treatment rendered either before or after the date of this document. A copy of this authorization shall be as valid as the original.