MARYSVILLE PHYSICAL THERAPY
211 STOCKSDALE DRIVE
MARYSVILLE, OH 43040
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
_____
_____

Patient Name: _____ Date of Birth: _____

Last 4 digits of SSN#: _____ Date of Treatment: _____

I, _____, hereby authorize and request you to permit Marysville Physical Therapy at 211 Stocksdale Drive, Marysville, OH 43040, to receive and examine copies of any and all records, reports, and charts as indicated in the following:

___XX____ Medications _____ Surgical Report (if applicable)

___XX_____ Last visit notes _____ Protocol

___XX_____ RX/Order __XX_____ Imaging Reports

___XX_____ Anything pertinent to continuity to care

The requested information is released for the following purpose and that purpose only. Any other uses are forbidden.

_____ Continuity of Medical Care for Physical Therapy

A copy of this authorization made by duplicating purpose shall be valid for all purposes as the original signed by me. I also understand that: I may revoke this authorization at any time and that in any event this authorization expires thirty (30) days from the date of my signature or as otherwise specified by date, event or condition as follows:_____.

_____ _____
Signature Date

_____ _____
Next of Kin and Relationship to Patient (if patient is a minor or Incompetent) Date