MARYSVILLE PHYSICAL THERAPY
211 STOCKSDALE DRIVE
MARYSVILLE, OH 43040
Phone (937) 644-3311 Fax (937) 644-0373
MARK E RAMSEY, P.T., OCS, C.H.T. ANN-MARIE WALTERS, P.T., CERT. MDT
AMY MERRY, MHS, P.T. ANGELA R LANDSETTLE, M.P.T.

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 ___XX____ 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.

___XX_____ 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 ninety (90) 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