Authorization for Release of Records

Patient Printed Name _____

Please fill in and sign the applicable section below for the Records Release of your request. Thank you.

Records Release to MROWKA PHYSICAL THERAPY from other Healthcare Providers
I authorize the release of pertinent clinical and/or account information to Mrowka Physical Therapy, P.C.

_____
Patient or Guardian Signature Date

_____ _____
Witness Signature Date

Records Release to Other Healthcare Providers
I authorize the release of pertinent clinical and account information from Mrowka Physical Therapy, P.C. to the following other healthcare practitioners upon your/their request:

1._____

2. _____

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Signature Date

Records Release to Attorney
Please list any Attorney that you would like to authorize release of your medical records to upon their request.

Name _____

Address _____

_____ _____
Patient or Guardian Signature Date

_____ _____
Witness Signature Date