

PHYSICAL THERAPY SPECIALISTS CLINIC

Authorization for release of information

Date _____

Patient's name _____

Patient's date of birth _____

I, _____, do hereby authorize PHYSICAL
(name of patient)

THERAPY SPECIALISTS CLINIC, INC to release to

_____ (requestor of information- physician, attorney, caseworker, coach, etc.)

**the following: records of evaluations, progress notes, tests, or any other
information specifically requested from _____ through**

(beginning date of request)

_____ for the purpose of _____.

(ending date of request if applicable)

(reason for request, i.e. litigation, physician change,
update on condition, etc.)

**I understand that this authorization covers information available as of the date I
signed this authorization and that any information subsequently requested will
require additional authorization. I also understand that a copy of this
authorization shall have the same force and effect as the original authorization.**

(patient's signature or that of authorized agent)

(relationship to patient)

(date)

I, _____, released the above information on
(authorized representative of PTSC)

(date information released)

(signature of authorized PTSC representative)

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