RELEASE OF MEDICAL RECORDS

NAME OF PATIENT: _____

DATE OF BIRTH:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

I hereby release **AWARE PHYSICAL THERAPY**, its Administrator or designee from all legal responsibility or liability that may arise for the release of this information or these records and I authorize the release of information contained in my record to:

NAME/ COMPANY_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP:_____

TELEPHONE: (___)_____ FAX: (___)_____

INFORMATION TO BE RELEASED	DATES
☐ Initial Evaluation	_____
☐ Progress Notes	_____
☐ Daily Notes	_____
☐ Discharge Summary	_____
☐ Other	_____

This consent will expire ninety (90) days from the date below. I understand that I have the right to withdraw this authorization at any time, except to the extent for action that has already been taken by my authorization. Revocation of authorization for release of medical record information must be in writing and send to the Administrator.

Patient Signature _____ Date_____

Witness Signature_____ Date_____