



## Authorization To Release Medical Information

This will authorize \_\_\_\_\_ to release to Andover Physical Therapy information from the medical record(s) maintained regarding all injuries, medical history, and physical condition.

The information to be disclosed is:

- |   |   |
|---|---|
| <input type="checkbox"/> Discharge Summary                    | <input type="checkbox"/> Operative Reports      |
| <input type="checkbox"/> Consultation Reports                 | <input type="checkbox"/> Pathology Reports      |
| <input type="checkbox"/> History and Physical Exam            | <input type="checkbox"/> X-ray Reports          |
| <input type="checkbox"/> Laboratory Reports                   | <input type="checkbox"/> Doctors Progress Notes |
| <input type="checkbox"/> EEG's, EMG's, EKG's, MRI's, CT Scans | <input type="checkbox"/> Physical Therapy Notes |
| <input type="checkbox"/> Occupational Therapy Notes           | <input type="checkbox"/> Doctor Statements      |
| <input type="checkbox"/> All Medical Records                  | <input type="checkbox"/> Other (Specify)        |

The information is needed to assist in development of a physical therapy plan of care.

I understand that I may revoke this consent at any time and that upon fulfillment of the above stated purpose this consent will automatically expire without my express revocation.

A photocopy or fax copy of this authorization shall be considered as valid as the original.

\_\_\_\_\_  
(Signature of Patient/Guardian)

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

SS#: \_\_\_\_\_