REFORM PHYSICAL THERAPY
Don't neglect your health, reform it

Release of Information

I authorize Reform Physical Therapy to release and receive information regarding my care to those companies/individuals listed below unless otherwise indicated. This information may be in the form of typed or written notes, faxed information, billing information, or verbal discussions.

1. My Referring Physician: _____
2. My Primary Care Physician: _____
3. My Insurance Carrier: _____
4. My Attorney's Office: _____
5. Other: _____

If needed/necessary, I authorize Reform Physical Therapy to discuss my appointments and scheduling with the following individuals:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Emergency Contact:

Name:_____

Phone Number: _____

Relation to patient: _____

I have read this form and have had the opportunity to ask any/all questions. I have sufficient information to give my informed consent to release my information.

Printed Name: _____

Signature: _____

Date: _____