

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 Phys	cian:
2. My Primary Care P	ysician:
3. My Insurance Carr	er:
4. My Attorney's Offi	e:
5. Other:	
If needed/necessary, I auth with the following individu	orize Reform Physical Therapy to discuss my appointments and scheduling
Name:	Relationship:
Name:	Relationship:
Name:	Relationship:
Emergency Contact:	
Name:	
Phone Number:	
Relation to patient:	
	d have had the opportunity to ask any/all questions. I have sufficient to give my informed consent to release my information.
Printed Name:	
Signature:	·····
D. L.	