Physical Therapy Medical Authorization Release Form

Patient Information

Full Name

Date of Birth

Address

Phone Number

Email

Insurance Information

Insurance Provider

Policy Number

Group Number

Insurance Phone Number

Authorization for Release

The undersigned hereby authorizes the following providers or entities to release any and all medical records or information regarding my physical therapy evaluation and/or treatment as necessary for processing claims and coordinating care:

Purpose of Release

To be released to (Insurance/Recipient):

Authorization Terms

☐

This authorization is valid for one year from the date signed below or until revoked in writing.

☐

I understand that I may revoke this authorization at any time by submitting a written request.

☐

I understand that treatment, payment, enrollment, or eligibility for benefits will not be conditioned upon my signing this authorization.

Patient/Guardian Signature

Date