STABILIZE PHYSICAL THERAPY
PHONE 949 631-3321 FAX 949 335-0619
e-mail admin@stabilizept.com

PATIENT AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize and grant permission to STABILIZE PHYHSICAL THERAPY to communicate with any health care professional that rehabilitation of my/patient's condition may indicate.

I hereby authorize and grant permission to STABILIZE PHYSICAL THERAPY to release information regarding my/patient's condition and my/patient's ability to return t normal activity or work to my physician, insurance company/employer/lawyer or their representative.

I hereby authorize and grant permission for the release of my/patient's medical records to STABILIZE PHYSICAL THERAPY, from other medical professionals, for the purpose of physical therapy evaluation and treatment.

My signature below shall serve as authorization for my physicians to provide copies of requested medical records.

A photocopy of this document is as valid as the original.

SIGNATURE of Patient or Legal Representative _____ DATE_____

PRINTED NAME of patient _____ Date of Birth_____