Elkins Physical Therapy Service
Phone: 304-636-2340
Fax: 304-636-1583

Authorization to Release Medical Information

Patient Name: _____ Date of Birth: _____

I authorize Elkins Physical Therapy Service to provide any/all my medical information to the following:

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

Name: _____ Relation: _____

This authorization will remain in effect for one year from the date of the signature below, unless you specify a different date here: _____. You or your Personal Representative may revoke this authorization at any time by providing written notice however; your revocation will not apply to any previously released information.

Signature: _____ Date: _____