Authorized Physical Therapy Information Release

I authorize Elder Care Physical Therapy to release details related to my medical treatment to the individual(s) listed below upon their inquiry:

Name Relation

_____

_____

_____

_____

_____

_____

_____

_____ _____

Patient Signature **Date**

I DO NOT authorize Elder Care Physical Therapy to release details of my treatment to anyone.

_____ _____

Patient Signature **Date**