

# Advanced Rehabilitation Services, LLC

Specializing in Vestibular, Spinal, Orthopedic and TMJ Physical Therapy

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## Authorization for Release of Information

I hereby authorize \_\_\_\_\_  
to release my medical records to Advanced Rehabilitation Services, LLC for the  
purpose of providing necessary information for my care. The following checked areas  
are the categories of information I request to be sent at this time:

(Please check all that apply)

- \_\_\_\_\_ Please release my entire chart
- \_\_\_\_\_ Operative Report dated \_\_\_\_\_
- \_\_\_\_\_ X-Ray report dated \_\_\_\_\_
- \_\_\_\_\_ History and physical \_\_\_\_\_
- \_\_\_\_\_ Discharge summary dated \_\_\_\_\_
- \_\_\_\_\_ Physical Therapy notes dated \_\_\_\_\_
- \_\_\_\_\_ Other \_\_\_\_\_

I hereby consent to the release of the above information for the purpose of formulating  
an appropriate physical therapy plan at Advanced Rehabilitation Services.

A photocopy/fax of this document shall be considered as valid as the original. This  
release shall be in effect until revoked.

Name (Please print) \_\_\_\_\_

Date of Birth ~~EDWWED~~ \_\_\_\_\_

Social Security # \_\_\_\_\_

\_\_\_\_\_  
Signature of patient or guardian

~~EDWWED~~  
\_\_\_\_\_  
Date