

Advanced Rehabilitation Services, LLC

Specializing in Vestibular, Spinal, Orthopedic and TMJ Physical Therapy

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