Authorization for Release of Medical Records to Elite

Name: _____ Date of Birth: _____

Social Security Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Please Release my Medical Records from:

Name: _____

Tel: _____

Fax: _____

Address:_____

_____

TO:

Elite Physical Therapy Group, Inc
3446 Masonic Drive, Alexandria, LA 71301
PH: 318-443-3311 FAX: 318-443-0023

Please release a copy of all my medical records, including but not limited to, face sheets, progress notes, operative notes, laboratory results and diagnostic tests.

BY MY SIGNATURE, I AUTHORIZE RELEASE OF MY MEDICAL RECORDS:

Patient: _____ Date: _____