



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

I request and authorize Spine and Sport Physical Therapy to release healthcare information to:

Referring Physician: _____

Primary Care Physician: _____

Insurance Adjuster: _____

Attorney: _____

Family Member (s): _____

Patient Signature: _____ Date: _____

This authorization form is valid (1) year from signature date.