Release of Information

I ____________________________________ do hereby authorize the release of my Private Health Information,

FROM: Advanced Physical & Sports Therapy
880 W. Happy Canyon Rd. # 145
Castle Rock, CO 80108
Fax: (720) 733-3656

TO: ____________________________________
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____

Please forward the following information:

______Complete Medical Record

______ X-ray Reports

______ MRI Reports

______ CT Reports

______ Chart Notes

Date:__________________ Patient Signature ____

____
Signature of Parent or Guardian (if applicable)