



Douglas T. Heckenkamp M.P.T.

Release of Information

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

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

TO: _____

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)