AUTHORIZATION FOR RELEASE OF RECORDS AND/OR XRAYS

To: ____

Attn: ____

Fax #: ____________________ Telephone #: ____________________

Address: ____

I hereby authorize and request you to release the following:

______ All Records, X-Rays and MRI Reports

______ Records from (Dates of Service): ____________________

______ Diagnosis Codes (s): ____________________

Patient: ____________________ DOB: ____________________

To:

ProCare Physical Therapy

19033 E. Plaza Drive
Parker, CO 80134
PH: (303) 805-4497
Fax: (303) 805-3937

Patient Signature: ____

Signature of Legal Guardian (for patients under 18): ____________________

ProCare Physical Therapy: ____________________ Date__________