|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Full Name:** | | | | | **Date:** | | | |
|  | | | | |  | | | |
| **Previous Name:** | | | | | **Social Security #:** | | | |
|  | | | | |  | | | |
| I request and authorize: | | | |  | | | | |
|  | | | | Phone: | | | | |
|  | | | | Fax: | | | | |
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|  | | | | | | | | |
|  | | | | | | | | |
| to release healthcare information of the patient named above to: | | | | | | | | |
|  | | | | | | | | |
| New Beginnings Physical Therapy, LLC  Jennifer Quintanilla, MPT | | | | | | | | |
| Phone – **(336) 701-0109** | | | | | | | | |
| Fax – **(336) 464-2314** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **This request and authorization applies to:** | | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | **Healthcare information relating to the following treatment, condition, or dates:** | | | | | | |  |
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|  | | | | | | | | |
|  | **All healthcare information** | | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
|  | **Other:** |  | | | | | | |
|  | | | | | | | | |
|  | | | | | | | | |
| **Patient Signature:** | | |  | | | **Date:** |  | |