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| --- |
| **AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION** |
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|  |
|  |
| **Full Name:** | **Date:** |
|  |  |
| **Previous Name:** | **Social Security #:** |
|  |  |
| I request and authorize: |  |
|  | Phone: |
|  | Fax: |
|  |
|  |
|  |
| to release healthcare information of the patient named above to: |
|  |
| New Beginnings Physical Therapy, LLCJennifer 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:** |  |
|  |
|  |
|  |
|[ ]  **All healthcare information** |
|  |
|  |
|[ ]  **Other:** |  |
|  |
|  |
| **Patient Signature:** |  | **Date:** |  |