



**AUTHORIZATION AND CONSENT  
To Release and Disclose Medical Information**

The undersigned hereby authorizes and consents to the release and disclosure of medical information by Impact Physical Therapy, LLC.

PATIENT NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_ SS# \_\_\_\_\_

The information being disclosed for the following treatment period:

\_\_\_\_\_

Release and disclosure of medical information to: \_\_\_\_\_

\_\_\_\_\_

The purpose for which this disclosure is to be made: \_\_\_\_\_

\_\_\_\_\_

*This consent is subject to revocation at any time, except to the extent that action has already been taken. This consent will expire six months from the date it is signed. I recognize that the records disclosed may contain information that is protected by federal and state law and I specifically consent to the disclosure of such information.*

DATE: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_

Patient

\_\_\_\_\_  
Other person authorized to sign for patient

WITNESS: \_\_\_\_\_

For office use only:

The following ( ✓ ) documents have been disclosed to the requested party:  Plan of Care  Progress Reports

Discharge Summary  Chart Notes  Insurance/Billing Information  Other \_\_\_\_\_