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Medical Records Release Form

I, _____ do hereby authorize and give permission to all physicians, hospitals, and all other health care providers who have rendered medical care, health care, or related services to me, to give Garner & Riley Physical Therapy (and any person acting on their behalf) complete access to all of my medical records (and all records related thereto) pertaining to the diagnosis and treatment of any and all injuries, diseases, illnesses, and medical conditions. This release is given for the purpose of the evaluation and documentation of my medical history in connection with the provision of physical therapy services to me by Garner & Riley Physical Therapy.

A photocopy of this authorization shall be as valid as the original.

Signature

Date

Party authorized to release information:

