Beyond Physical Therapy, PLLC

ANDREW CIESLIK PT, MS, CKTP

TOMASZ GRASS PT, MS, COMT, CMP, CKTP

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENT NAME: _____ DATE OF BIRTH:_____/_____/_____

SSN: _____

I understand that there are charges associated with this request and I will be billed accordingly. I hereby request and authorize Beyond Physical Therapy, PLLC, to release the below specified information related to the treatment of the above named patient, which may be considered privileged or confidential.

☐ ONLY DAILY TREATMENT NOTES AND ASSESSMENTS FROM THIS SPECIFIED TIME PERIOD: _____

☐ COMPLETE RECORD (ALL PAGES INCLUDING INTAKE FORMS, MEDICAL HISTORY, DR'S ORDERS, CHARGE SHEETS) FROM THIS SPECIFIED TIME PERIOD: _____

☐ ITEMIZED BILLING STATEMENT

☐ OTHER: _____

My permission is given for the requested information to be faxed or mailed to the following:

_____

_____

_____

FAX #: _____

PATIENT SIGNATURE: _____ DATE:_____

If all pages were not received or you are not intended recipient of this document, please contact our office immediately.

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