ADIRONDACK PHYSICAL THERAPY AND SPORTS REHABILTIATION, P.C.

Authorization for Release of Medical Record Information

Date: _____

Patient ID: _____

Name: _____

Street: _____

City: _____

Date of Birth: _____

Adirondack Physical Therapy and Sports Rehabilitation is hereby authorized to release to: _____

The bearer of this authorization is entitled only to review the medical record of:

_____

For the set period: _____

Adirondack Physical Therapy and Sports Rehabilitation is hereby released from all legal liability which may arise from the release of this information. This authority extends to the furnishing of copies of any and all parts specifically requested from the records. This consent to release may be revoked by me at any time, but not retroactive to the release of the information already released in good faith. The date of this authorization must not precede the dates of the information requested. This authorization will be considered valid for a period of ninety days from this date.

_____ _____

Patient Executor, Guardian, Etc.

_____ _____

Date Signed Witness