TRUE CARE PHYSICAL THERAPY AND REHABILITATION, PLLC

14815 W. Bell Road. Suite 110 Surprise, AZ 85374
Phone 623-777-1870 Fax 623-777-1403

Authorization to Release Medical Records
To True Care Physical Therapy and Rehabilitation, PLLC

Patient Name_____ DOB_____
Nombre del paciente Fecha de Nacimiento

This authorization releases True Care Physical Therapy and Rehabilitation, PLLC and any of its staff, employees, and agents of any responsibility for information contained in such records released in case of loss or theft from any person, or distress of any type caused by me or others. True Care Physical Therapy and Rehabilitation, PLLC will not be held liable for any misuse or misunderstanding of the information contained herein as a result of this release.

From: _____
Physician's Office/ Day Care/ Parent Name)
Oficina del Medico/Guarderia /Nombre de los padres/ Guardian legal

_____
(Address/ City/ State/ Zip)
Domicilio/Ciudad/Estado/Codigo Postal

_____
Phone Number Fax Number (please note will not call prior to faxing)
Numero de telefono Numero de Fax

To Release Information to: True Care Physical Therapy and Rehabilitation, PLLC
14815 W. Bell Road. Suite 110
Surprise, AZ 85374
Phone: 623-777-1870 Fax: 623-777-1403

Type of records requested: (check one)
Tipo de informacion autorizada (marque una)

_____ All Medical Records
Todo el expediente medico

_____The following described records only (specify types and dates) _____
Solo los siguentes expedients medicos (especifique tipo y fechas)

_____

_____**DO NOT RELEASE THESE RECORDS (specify types and dates) _____**
No libere este expediente medico (especifique tipo y fechas

_____

This authorization shall be considered invalid after 90 days. I may revoke the authorization at any time by providing True Care Physical Therapy and Rehabilitation, PLLC written notice of revocation. However, I may not revoke the authorization retroactively for information already rendered. I hereby waive all provisions of law and privilege relating to the disclosure hereby authorized.

_____ _____
Signature and Name of Patient or Legal Guardian Date
Firma de los padres o Guardian legal Fecha de hoy

_____
Relationship to Patient
Parentesco con el paciente **IF PATIENT IS 18 YRS OR OLDER- THEY MUST SIGN THIS RELEASE FORM**