EMPIRE
Sports Physical Therapy and Rehabilitation

Personal Release of Medical Information

Date: _____

Patient Name: _____

D.O.B.: _____ SS #: _____-_____-_____

I would like to give *Empire Sports Physical Therapy and Rehabilitation* authorization to release my health/ billing information to all of the following parties listed below: (Please exclude Physicians. **This is strictly for any of your family members or friends whom you entrust with your healthcare information**.)

	Name	D.O.B	Relationship
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

If you Do Not wish to list or release any of your private healthcare information, please check NA box below:

Not Applicable: ☐

*You may revoke (cancel) this authorization at any time. Revocations (cancellations) MUST BE MADE IN WRITING and mailed to, Empire Sports Physical Therapy and Rehabilitation. This authorization is good for one year from original date.

Patient Signature: _____

Witness: _____