|  |  |
| --- | --- |
| **cid:1adda648b919f62b496d81ba316f696ba5fddb42@zimbra**  | **C**  **Allied Physical Therapy** **Consent and release** |

**Please initial your authorization.**

***CONSENT FOR CARE AND TREATMENT***

**\_\_\_\_\_\_** I, the undersigned, so hereby agree and give my consent and authorization for Allied Physical Therapy to provide examination, treatments and services by a physical therapist to myself/designee. I realize and certify that no guarantee or assurance has been made as to the results that may be obtained for such examinations, treatments and services.

***RELEASE OF RECORDS***

**\_\_\_\_\_\_** I authorize Allied Physical Therapy to release any and all requested information pertaining to treatment necessary to process a claim(s) for physical therapy benefits (Physician, Insurance Company, Attorney, Etc.). I authorize Allied Physical Therapy to obtain medical records / reports as they pertain to my diagnosis, treatment, prognosis and other pertinent data to my treatment.

 \_\_\_\_\_\_I authorize Allied Physical Therapy to release records to my spouse, parents, and adult children.

 **\_\_\_\_\_\_**I authorize Allied Physical Therapy to release records to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

 (relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

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Printed Name DOB

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Signature Date

Please FAX to 207-778-3486

Or, mail to: Allied Physical Therapy

 128 Middle Street

 Farmington, Maine 04938

Thank you!