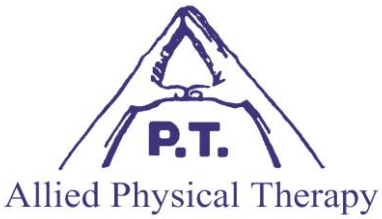

Allied Physical Therapy

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 _____)

_____ _____
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!