Balanced Physical Therapy, LLC
900 NE 139th St. Suite 102
Vancouver, WA 98685
(360) 573-3611 Fax: (360)573-3880

Authorization for Release and Disclosure of Medical Information

Patient Name: _____

Date of Birth: _____ Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____

Information to be released:

I _____authorize Balanced Physical Therapy to send medical information pertaining to me dated from _____ to _____.
Fax to _____located at _____
_____ Phone:_____
Fax: _____ for the purpose of _____
related to _____.

Information to be obtained:
Please fax back to BPT @ 360-573-3880

I _____authorize _____
located at_____ Phone:_____
Fax: _____ to release information dated from _____ to _____ to Balanced Physical Therapy, LLC at 900 NE 139th St. Suite 102 Vancouver, WA 98685, Phone 360-573-3611, Fax 360-573-3880,
for the purposes of _____
related to _____.

This consent is good for 90 days from date signed by patient as per RCW70.020.030 (6).

Patient Signature: _____

On this ____ day of _____, _____

Parent or Legal Guardian Signature, if applicable: _____