

AUTHORIZATION FOR MEDICAL INFORMATION

This authorization or photocopy hereof, will authorize you to furnish all information you may have regarding my condition while under your observation and treatment: including the history obtained, x-ray and physical finding, diagnosis and prognosis.

Patient's Signature

Date

Please indicate any medical professionals you want to receive your physical therapy evaluation and/or progress reports. You do not need to list the doctor who referred you to our clinic since he/she will receive information from us automatically.

1. **Physician Name:** _____ Specialty _____
Address: _____ Phone: _____
City & State: _____ Zip Code: _____

2. **Physician Name:** _____ Specialty _____
Address: _____ Phone: _____
City & State: _____ Zip Code: _____

3. **Physician Name:** _____ Specialty _____
Address: _____ Phone: _____
City & State: _____ Zip Code: _____

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SPT 2/09

SUMMIT PHYSICAL THERAPY