Harmony Lymph & Pelvic Physial Therapy

Patient authorization form to release medical records and to contact other medical providers.

Date _____
Patient Name:_____
DOB:_____
Medical provider to release forms:_____
_____
Phone # (_____) _____
Fax # (____)_____
Type of records to be released:
_____
_____
_
I "_____" authorize the release of my medical records to Erica Gould, PT of Harmony lymph & pelvic physical therapy. These records will be used to help guide my physical therapy plan of care. I also authorize Erica Gould PT to contact and exchange medical information regarding my condition via phone/fax as needed.

_____ _____
Patients signature Date

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