# *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:

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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

## 2959 W Midway Rd.

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