

REQUEST FOR RELEASE OF MEDICAL RECORDS

PATIENT INFORMATION:

Name:

Address:

Phone Number:

DOB:

Soc. Sec. Number:

I authorize:

Lebec Physical Therapy, PC

55 Southwest Drive

Sedona, AZ 86336

928-282-5050

928-282-5945

To Release All Medical Records To:

Sedona Physical Therapy, LLC

dba Lebec Physical Therapy

55 Southwest Drive

Sedona, AZ 86336

928-282-5050

928-282-5945

I hereby release all medical records held by Lebec Physical Therapy, PC to Sedona Physical Therapy, LLC. I understand that this may include information regarding medical, surgical, psychiatric, drug, and HIV testing and/or treatment and counseling. I release Lebec Physical Therapy, PC and Sedona Physical Therapy, LLC from any and all costs, liability or damages resulting directly or indirectly. I understand that I am entitled to receive a copy of this authorization. I understand that I may withdraw this authorization in writing any time. I understand that this authorization will expire on 01/01/2027, unless otherwise specified.

Signature: _____ Date: _____