6701 Sunset Drive. Suite 103 South Miami, Florida 33143
Tel: 305-667-1918 Fax: 786-534-5730

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I,_____, here by authorize_____

_____

To release any and all of my medical records including MRI, CT, X-RAYS to Elite Physical Therapy, by mail and/or fax.
Thank you for your prompt cooperation.

_____ _____
Patient Name Witness Name

_____ _____
Patient Signature Witness Signature

_____
Date