



Bodies in Balance, PLLC

Orthopedic Manual Physical Therapy

Pilates-Based Rehabilitation

Biomechanical Evaluation

P.O. Box 829 • Chattanooga, TN 37401 • Tel: 423.255.6105 • Fax: 423.756.4782

Information Release Authorization

Please complete the following patient information to facilitate identification of records:

Last Name: _____ First Name: _____ MI: _____

Maiden Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

1. The need for the record is: _____

2. I, _____, hereby authorize:

Bodies in Balance Physical Therapy, PLLC
P.O. Box 829
Chattanooga, TN 37401

TO RELEASE ANY AND ALL INFORMATION IN MY PHYSICAL THERAPY MEDICAL RECORDS

PLEASE RELEASE ONLY THE INFORMATION RELATING TO SPECIFIC DATES OF: _____

I understand that this authorization, unless expressly limited by me in writing will extend to all aspects of treatment or sessions. I release the health care facility and its staff from all legal responsibility or liability that may arise from the release of this information. I may revoke this consent at any time, except when action has been taken. This release expires 90 days from the below date.

Sign: _____ Date: _____