Release of Information Form

I, _____, the undersigned, hereby authorize the following individual to discuss my medical bills with Axcess Physical Therapy, LLC:

Name:_____

Address:_____

Patient Information:

Patient Name (Last, First, Middle):

_____

Address:

_____

Phone: (_____)_____-_____ Date of Birth (mm/dd/yy):_____/_____/_____

NOTE: I understand that this release is valid for a period of one hundred and twenty (120) days. I further understand that I may cancel or revoke this authorization at any time in writing.

Dated this _____ day of _____, _____

By my signature below, I consent to the release of the above listed information / documents.

Printed Name of Patient: _____

Signature of Patient: _____