PROGRESSIVE PHYSICAL THERAPY CENTER

PATIENT AUTHORIZATION TO RELEASE MEDICAL INFORMATION

This is to certify that I,_____hereby authorize Progressive Physical Therapy Center, LLC to request and receive medical reports and information pertaining to my health in reference to injuries and/or related to my health status for the purpose of informative review and collaboration by a physical therapist and clinical staff. I authorize and consent to my medical information being faxed, emailed, direct mail, and/or directly verbally communicated to the physical therapists at Progressive Physical Therapy Center, LLC.

I certify that the information I have reported regarding my insurance coverage and/ or representing my legal counselor is correct. I authorize the release of my physical therapy record, including medical information and billing statements for the services rendered for this or any related claim, to be sent to legal representation, insurance company, and/or reimbursing agency.

This is to certify that I hereby authorize Progressive Physical Therapy Center, LLC, to apply for benefits, including PIP, on my behalf for covered services rendered to me or my dependents. I request that payments from any insurance reimbursing agency be made directly to Progressive Physical Therapy Center, LLC. I permit a copy of this form to be used in place of the original.

I agree to give my consent to Progressive Physical Therapy Center, LLC, to furnish rehabilitation services considered necessary and proper in the treatment of my medical condition. I understand and agree to consent for physical therapy treatment and authorization for the disclosure of medical records.

_____
Print Name:

_____ ____/____/_____
Patient/guardian signature: Date: