Central Missouri Physical Therapy
&
Hand Rehabilitation

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Authorization to Release Medical Records

I hereby authorize any and all therapist who have examined, evaluated, and/or treated me to furnish to ______________________________ all records and other data or information regarding medical history, treatment, and/or diagnosis and permit them to make copies thereof. A photocopy of this document shall be as effective as the original.

Dated this __________ day of _________________________ 20___.

____

Signature

____

Address

____

City, State, Zip Code

____

Telephone Number

____

Cell Number