Niagara Physical Therapy
736 Cayuga Street
Lewiston, NY 14092
Phone: 716-754-7220 Fax: 716-754-9218

Patient Authorization for Release of Medical Records

Patient's Name: **DOB:**
Address:

Please check all information that applies:
☐ Chart notes
☐ MRI reports
☐ X-rays
☐ CAT scan
☐ Other (please specify):
☐ All of the above

Please indicate which body part and/or side:____

☐ I give my authorization to release the above protected information to **NIAGARA PHYISCAL THERAPY.**

☐ I also authorize **NIAGARA PHYSICAL THERAPY**, to **release** any of the above protected information, and/or to speak to the following **person or organization**, (other than referring/primary doctor(s) when needed

Name: _______________________________________

Relationship to Patient: _________________________

Phone:

This authorization will end on the following date: **eight years from date below**

Signature of patient: ____ Date:__________