Brooklyn Body Works Physical Therapy, P.C.
Sports and Orthopedic Rehabilitation

Medical Records Release Form

Patient's Name: _____

Date of birth: _____

Address: _____

_____

Telephone Number: (____) _____-_____

Please release my medical records

From:

Name of provider/office: _____

Office Address: _____

_____

To: _____

_____

_____

_____

Please release all records, including but not limited to progress notes, operative notes, laboratory test results, diagnostic tests and x-ray.

I hereby authorize the release of my medical records as provided above.