MEDICAL RECORDS RELEASE FORM

PATIENT'S NAME:	**DATE OF BIRTH:**
ADDRESS:	
TELEPHONE NUMBER:	

NAME OF INDIVIDUAL/ OFFICE:
ADDRESS:
PHONE NUMBER:
FAX NUMBER/ EMAIL:

I hereby authorize **Brooklyn Body Works Physical Therapy, PC** and **Brooklyn Body Works Physical Therapy & Wellness** to obtain and disclose my health records to the party listed above:

THESE RECORDS MAY INCLUDE BUT ARE NOT LIMITED TO PROGRESS NOTES, OPERATIVE NOTES, LABORATORY TEST RESULTS, DIAGNOSTIC TESTS, X-RAY AND MRI REPORTS.

_____ _____

SIGNATURE OF PATIENT/ GUARDIAN DATE:

_____

NAME OF PATIENT/ GUARDIAN

BROOKLYN BODY WORK PHYSICAL THERAPY, PC
202 UNION AVENUE, STE. K
BROOKLYN, NY 11211
P. (718) 387-7420 F. (718) 387-7421

BROOKLYN BODY WORKS PT & WELLNESS
101 N. 10TH STREET, STE 302
BROOKLYN, NY 11249
P. (718) 702-6105 F. (718) 702-8659