KEE
PHYSICAL
THERAPY

Authorization to Release Medical Records

I, _____, authorize KEE PHYSICAL THERAPY to release photocopies of my medical records to:

Office/Provider Name: _____

Phone Number: _____

Fax Number: _____

I understand that I am not protected from re-release of this information by a designated third party. I understand that I may revoke this release in writing to KEE PHYSICAL THERAPY at any time. I also understand that this release is effective for six (6) months from this date.

Signature: _____ Date: _____

Print Name: _____

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