AZ PHYSICAL MEDICINE & REHABILITATION, PC

Authorization to Release Medical Information

Patient Name: _____ **Date of Birth:** _____

Best Contact Phone Number: _____

By signing this form I _____, authorize the release of confidential health information pertaining to myself including medical records and summary/narrative of my protected health information to my designated entity/company.

_____ _____

Patient Signature **Date**

_____

Witness Signature

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