AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

New Motion
Physical Therapy Inc., PS

9419 Coppertop Loop NE
Bainbridge Island, WA 98110
206-842-2428 FAX 206-842-2890

Patient's Name_____

DOB _____

SSN: _____

Next Appointment:_____

I, _____, Hereby Authorize _____
(name/patient) (name/facility)
to release to **New Motion Physical Therapy, Inc.**, 9419 Coppertop Loop NE, Bainbridge Island, WA 98110, FAX(206) 842-2890, phone (206) 842-2428, the following medical information contained in the patient's medical record.

Such disclosure shall be limited to the following medical records, a specific type of information, or dates of treatment:

Specific Medical Condition(s) _____

and/or Specific Timeframe(s) _____

Type of Records Needed:

☐ Operative Reports
☐ Consultation Reports
☐ Other (specify) _____

☐ Radiology Reports
☐ X-Ray ☐ MRI ☐ Bone Scan
other radiology reports (specify)_____

Signature: _____ Date:_____
Patient or Guardian

Witness: _____ Date:_____
Signature Printed Name

If signed by other than patient, indicate relationship: _____

Proof of relationship required for guardian or legally appointed attorney. _____

The attached medical information pertaining to the patient named above is confidential and legally privileged. The facility stated above has provided it to New Motion Physical Therapy, Inc. as authorized by the patient. The recipient may not further disclose the information without the express consent of the patient or as authorized by law.