

Balanced Physical Therapy, LLC
900 NE 139th St. Suite 102
Vancouver, WA 98685
(360) 573-3611 Fax: (360)573-3880

**Authorization for Release and
Disclosure of Medical Information**

Patient Name: _____

Date of Birth: _____ Phone #: _____

Address: _____ City: _____

State: _____ Zip: _____

Information to be released:

I _____ authorize Balanced Physical Therapy to send
medical information pertaining to me dated from _____ to _____.
Fax to _____ located at _____
Phone: _____
Fax: _____ for the purpose of _____
related to _____.

Information to be obtained:

Please fax back to BPT @ 360-573-3880

I _____ authorize _____
located at _____ Phone: _____
Fax: _____ to release information dated from _____ to
_____ to Balanced Physical Therapy, LLC at 900 NE 139th St. Suite 102
Vancouver, WA 98685, Phone 360-573-3611, Fax 360-573-3880,
for the purposes of _____
related to _____.

This consent is good for 90 days from date signed by patient as per RCW70.020.030 (6).

Patient Signature: _____

On this ____ day of _____, _____

Parent or Legal Guardian Signature, if applicable: _____