WHITEFISHTHERAPY & SPORT CENTER
SPEECH • PHYSICAL • OCCUPATIONAL • REHABILITATION • TRAINING

Records Release Authorization Form

Patients Name_____
Date of Birth: _____/_____/_____
Social Security Number: _____-_____-_____
Mailing Address: _____
City _____ State_____ MT _____ ZIP _____
Phone: ( ) _____-_____ Cell phone: ( ) _____ - _____

☐ Daily Treatment Note(s) ☐ Complete Medical/Financial Records

☐ Financial Records/Statements Only ☐ Other (please specify)
_____

I hereby request that my medical records be released to the following physician/person/facility/entity and/or those directly associated in my medical care:

Name:_____
Mailing Address: _____
City _____ State_____ MT _____ ZIP _____
_____

☐ Fax ☐ Phone ☐ Email_____

This authorization may be revoked at any time by providing written notice of revocation. It will remain in effect indefinitely unless revoked.

Signature: _____

Printed Name:_____

Date: _____

Updated May 2021