Buffalo Back & Neck Physical Therapy, P.C.
1060 Niagara Falls Blvd. Suite 5 Tonawanda, NY 14150
Phone: 716-836-2225 Fax: 716-836-2712

MEDICAL RECORD RELEASE REQUEST

Patient Name: _____ Date of Birth: _____

Current Address: _____

City: _____ State: _____ Zip Code: _____

I request and authorize Buffalo Back & Neck Physical Therapy, P.C. to release my medical records from the dates of _____ to _____. Records are to be released to: (circle one: self / physician / family member / attorney / other _____)

Name: _____
Address: _____
_____
_____
Phone: _____
Fax: _____

Am aware that this release expires 1 year following the date of signature. I am also aware that I may void this authorization before that time by providing my request in writing to the address provided below.

Buffalo Back & Neck Physical Therapy, P.C.
1060 Niagara Falls Boulevard, Suite 5
Tonawanda, NY 14150
Phone: 716-836-2225
Fax: 716-836-2712

Patient Signature: _____ Date: _____

Guardian Signature: _____ Relationship: _____

** If patient is under 18 years of age, both client and a parent / legal guardian must sign this form for consent to be given.