Dr. John Cipriani, DC
Dr. Nevin Markel, DC
Dr. Wesley Pope, DC
Dr. Erin Markel, DPT
Katherine Trotta, MSPT

Authorization to Release Medical Information

Patient Name | Date of Birth | Phone Number

Street Address | City | State | Zip Code

Please select the appropriate option below:

___Send records to (select one):
- __ My insurance provider
- __ Me (personal use)
- __ Another physician
- __ My attorney

___Obtain records from (select one):
- __ My insurance provider
- __ Me (personal use)
- __ Another physician
- __ My attorney

I authorize Performance Rehab Associates to release my medical records to/obtain my medical records from:

Name | Company/Office

Street Address | City | State | Zip Code

Phone Number | Fax Number

Signature of Patient or Parent/Legal Guardian | Date

I understand that my authorization is confidential, except for any action already taken in good faith and may be voided by Performance Rehab Associates or the named patient at any time for any reason. Unless otherwise indicated this release is valid for one (1) year from date of signature.

Please Note: The information contained in this document is privileged and confidential. It is for the use of the named recipient only; Performance Rehab Associates, its officers and employees are released from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.