Dr. John Cipriani, DC
Dr. Nevin Markel, DC
Dr. Wesley Pope, DC
Dr. Luke Keane, DC
Dr. Erin Markel, DPT
Dr. Kristine Royen, DPT
Katherine Trotta, MPT

Authorization to Release Medical Information

Date: _____

_____

Patient Name | Date of Birth | Phone Number

_____

Street Address | City | State | Zip Code

Please Check the Appropriate Box:

☐ Please send records to my insurance provider--- Dates: _____

☐ Please send records to me --- Dates: _____

☐ Please send records to another physician --- Dates: _____

☐ Please send records to my attorney --- Dates: _____

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

_____

Name | Company/Office

_____

Street Address | City | State | Zip Code

_____

Phone Number | Fax Number

_____

Patient Signature | Date

I understand that my authorization is confidential, except for any action already taken in good faith and may be voided by the Performance Rehab Associates or 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 name recipient only. Performance Rehab Associates, its officers and employees are release from legal responsibility or liability for the release of the above information to the extent indicated and authorized herein.