# LIFESTYLES
## Therapy & Wellness Center
*Personalized Solutions for Lasting Results*

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## AUTHORIZATION FOR RELEASE OF PATIENT HEALTH INFORMATION

Dated this day of ____________________

Patient Name ______________________ DOB ____________

I hereby consent and authorize the following disclosure of information from treatment records relating to my identity, diagnosis, prognosis or treatment. I understand that the type of information to be disclosed may include:

- History & Physical
- Diagnostic Test Results (X-Rays, MRI, etc)
- Clinic Notes

I further understand that the purpose of this disclosure is to evaluate my health status as it relates to Physical Therapy interventions. I also understand that unless revoked in writing, this consent will remain in force for the period of time necessary to effectuate the purpose for which it is given.

Patient/Guardian/Durable POA Signature ___________________________

Witness Signature __________________________