AUTHORIZATION TO RELEASE
PROTECTED HEALTH INFORMATION (PHI)

At New Dimensions Physical Therapy we value a team approach to care. As authorized by you, we communicate our findings in your medical record with members of our physical therapy staff as well as off site professionals involved in your care to insure continuity and quality in all of your treatments.

PATIENT NAME _____DATE_____

I hereby authorize New Dimensions Physical Therapy to release to the individual(s) or entity(ies), referenced below, copies of medical records pertaining to myself either written or verbal.

RELEASE TO:	Phone #
The professional staff at New Dimensions Physical Therapy*	512-328-8950
Personal Trainer(s) _____	_____
Acupuncturist_____	_____
Psychologist/Psychotherapist_____	_____
Massage Therapist_____	_____
Pilates Instructor_____	_____
Physician_____	_____
Chiropractor(s)_____	_____
Family Member_____	_____

*The professional staff at New Dimensions Physical Therapy consists of the following:
Rebecca Kern Steiner, PT - Mark Barber, PTA

Signature of Patient or Authorized Legal Representative:

_____Date_____