



**Consent to Release Medical Information**

To: \_\_\_\_\_

I, \_\_\_\_\_, hereby give my permission for Sage Physical Therapy & Wellness (provider) to receive my records/ radiographs including the dates of treatment from \_\_\_\_\_ to \_\_\_\_\_ - specifically all information you may have regarding my condition when under your observation or treatment, including history, findings, diagnosis, all radiographs and subsequent of further development.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

In the event that I wish to revoke the authorization in the future, I will submit in writing my desire to do so to Sage Physical Therapy & Wellness.

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Witness: \_\_\_\_\_

Social Security #: \_\_\_\_\_