David Stevenson Physical Therapy, Inc.

2055 Wood St., Suite 110, Sarasota, FL 34237
Phone: 941-330-1677 Fax: 941-330-1688

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient's Name:____

Address:____

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Patient's Birth:_______________________

I, _______________________________, hereby authorize David Stevenson Physical Therapy, Inc. to release my records to:

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Signature: _______________________

Date: _______________________