EW Motion Therapy LLC
4 Office Park Circle Suite 217 // Mountain Brook Alabama 35223
Phone 205.263.2770// Fax 205.263.0994 // ewmotiontherapy.com

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name (please print):_____ DOB:_____

Home Phone:_____ Cell Phone:_____

Email Address:_____ Clinic: _____

Patient'sAddress:_____

_____

☐ Please e-mail a copy of my medical records to this email address:

_____

☐ Please fax or email a copy of my physical therapy notes to my doctor.

Name of Doctor:_____

Fax Number:_____ E-mail Address: _____

Date Range of Notes:_____

PLEASE NOTE: *We will provide you with a copy of your medical records. If you need a copy of your medical records sent to another party (Lawyer, Insurance Company, etc.), please have the other party send a request for medical records to our office via mail, e-mail, or fax.*

The Medical Records Office Mailing Address:
EW Motion Therapy LLC
ATTN: Medical Records
4 Office Park Cir Ste 217
Mountain Brook AL 35223

The e-mail address is: MedicalRecords@ewmotiontherapy.com

The fax number for the medical records office is: (205)263-0994.

_____ _____
Signature of Patient or Authorized Agent Date

_____ _____
Printed Name of Authorized Representative Relationship to Patient

This authorization expires 90 days from the date signed.

REVISED JAN 2023