5245 Schaefer Road, Suite B
Dearborn, MI 48126
info@cure-pt.com
313-584-CURE (2873)

Authorization to Release Healthcare Information

Patient Name: ____

Last Middle Initial First

Alternative Names: ____

Social Security Number: ____

Phone Number: ____________________ **Email:** ____________________

Street Address: ____

City: ____________________ **State:** __________ **Zip Code:** __________

I request and authorize Cure Physical Therapy to release healthcare information of the above named to organizations that may make a formal request for my medical records: **Please check all that apply**

- ☐ **Primary Care Physician Practices**
- ☐ **Hospital Organizations**
- ☐ **Pharmacies**
- ☐ **Drug or Alcohol Treatments Centers**
- ☐ **Medical Diagnostic Companies**
- ☐ **Attorneys**
- ☐ **Physician Specialists**
- ☐ **Urgent Care Organizations**
- ☐ **Home Care Agencies**
- ☐ **Mental Health Facilities**
- ☐ **Laboratories**
- ☐ **Any other organization with a formal request**

______________________________ ____________________

Patient Signature **Date**