



ARIZONA STATE BOARD OF PHYSICAL THERAPY
4205 North 7th Avenue, Suite 208 Phoenix, Arizona 85013
(602) 274-0236 Fax (602) 274-1378

AUTHORIZATION FOR THE RELEASE OF RECORDS AND INFORMATION

Name _____ Date of Birth _____
Social Security Number _____ Telephone _____
(Optional)
Address _____

I authorize and request:

Health care provider _____
OR facility _____
Street Address _____
City, State, Zip _____
Telephone _____

To release information and legible copies of the records indicated below to:

Arizona State Board of Physical Therapy
4205 North 7th Avenue, Suite 208
Phoenix, Arizona 85013

_____ All physical therapy treatment and billing records to include all chart entries, diagnoses, test results, flow sheets, reports, daily records, and all other documents for the following dates: _____

_____ All medical records for visits on the following dates: _____

_____ All medical records related to the following diagnosis/symptoms: _____

_____ All billing records for services rendered on the following dates: _____

_____ All personnel records relating to the employment of _____

The disclosure of these records is required for official use, including investigation and possible administrative proceedings regarding alleged violations of the laws of the State of Arizona. A copy of this authorization is as valid as the original. This authorization is valid for a period of one year.

Signature _____ Date _____