

Release for Medical Records

Wetzler Integrative Physical Therapy Center
1151 Dove Street, Suite 100 Newport Beach, CA 92660
Phone: (949) 851-8228 Fax: (949) 851-8418
www.wetzlerptcenter.com

Patient Full Name: _____ Date of Birth: _____

I, _____, hereby consent to release my medical information from:

Name of Receiving Party

Street Address

City, State, Zip

Phone

Fax

To the office of:

Wetzler Integrative Physical Therapy Center
1151 Dove Street, Suite 100 Newport Beach, CA 92660
Phone: (949) 851-8228 Fax: (949) 851-8418

Please provide records via the following method

- Mail Fax Records to be picked up

Please include the following:

- All Records
 Progress Notes (Please specify dates of service or date range):

 Radiology Reports (Please specify dates of service or date range):

 Other: _____

Please forward these records: At your earliest convenience ASAP

Thank you.

Patient Signature: _____ Date: _____

If person other than patient is signing, please complete the following:

Print First and Last Name

Relationship to Patient