

Florence Therapy & Wellness Inc.

5529 Old US Hwy 93, Florence, MT 59833

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

To: _____
Doctor we are requesting patient information from

PATIENT INFORMATION (Please Print):

Specify type of records: _____

Patient Name: _____ Date of Birth: _____

Phone: _____

RELEASE MY MEDICAL RECORDS TO:

Florence Therapy & Wellness, Inc.
Fax: (406) 273-4341

Print Your Name: _____

Patient/Guardian Signature: _____ Date: _____

Mara Arlington, M.P.T, D.P.T. • Rachel Sherba, M.P.T. • Chris Phipps, O.T.R.
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