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:_____