17618 140th Ave NE
Woodinville, WA 98072
Phone (425) 402-9772
Fax (425) 402-9443

AUTHORIZATION FOR RELEASE OF RECORDS

I, ___________________________, the undersigned, hereby authorize:

______________________________	______________________________
Office or Doctor's Name	Address
	______________________________
	Address
(______)_____________________	(_______)____________________
Phone	Fax

To release to **PhysioCare at Woodinville** the complete history, and all records in your possession concerning my illness and/or treatment during the period from __________________ to ______________________.

Please send records to:
PhysioCare
17618 140th Ave. NE
Woodinville, WA 98072
Fax: (425) 402-9443

This voluntary consent is subject to my revocation at any time, and shall expire within 90 days of this release.

I hereby certify that I have received a signed copy of this authorization.

A photocopy or facsimile (fax) of this authorization shall be as valid as the original.

_______________________________________ ____________________
Signature of Patient (or patient's authorized representative) Date

Patient Name:____

Date of Birth:_____________________