The Institute for Orthopaedic & Sports Rehabilitation at The Carrell Clinic

9301 North Central Expressway Suite 451

Dallas, Texas 75231

Phone: 214-397-1581 Fax: 214-378-3356

Request for Release of Medical Records

I hereby authorize The Carrell Clinic to release the following information from the Physical Therapy treatment record of;

Patient Name _____

SSN _____ Date of Birth _____

Covering the period of treatment:

From _____ To _____

I agree to pay the fee of $25.00 for the provision of these records.

This information is to be released to:

Name _____

Address _____

City, State, Zip Code _____

Phone Number _____ Fax Number _____

Relationship to the Patient _____

I understand that this consent can be revoked at any time except to the extent that disclosure made in good faith has already occurred in reliance of this consent.

I understand that the information released could contain reference to or results of HIV Antibody (AIDS) testing.

Signed _____ Date _____