Apex Physical Therapy, P.C.

Medical Information Release Form

Date_________________

I, ____, authorize

Apex Physical Therapy, P.C.
1701 48th Street
Suite 120
West Des Moines, IA 50266
Tel: 515-224-1474 Fax: 515-224-1478

To release medical records to
Name____

Address____

____

Phone__________________________ Fax ____________________

Concerning:____

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___________________________________ D.O.B.________________
Signature

____
Signature of Witness