

AUTHORIZATION TO RELEASE INFORMATION

DATE: _____

I HEREBY AUTHORIZE **CORNERSTONE PHYSICAL THERAPY LLC**, 51 SHERMAN HILL ROAD, WOODBURY CT 06798, TO RELEASE ANY AND ALL INFORMATION INVOLVED IN MY CARE TO ANY DOCTOR, INSURANCE COMPANY, OR ATTORNEY INVOLVED WITH MY CARE.

NAME OF PATIENT: _____

SIGNATURE OF PATIENT: _____
OR LEGAL GUARDIAN

NAME OF WITNESS: _____

SIGNATURE OF WITNESS: _____