Central Missouri Physical Therapy, LLC
dba PEAK Sport and Spine
3301 Berrywood Drive, Suite 204
Phone: (573) 449-6082 Fax: (573) 449-0401
www.peaksportspine.com

Release of Medical Records

_____ _____
Patient's Last Name, First Name, MI Date of Birth

_____
Address City State Zip

_____ _____
Preferred Phone Number Alternate Phone Number

PEAK Facility Attended/Attending: _____

☐ **I authorize Central Missouri Physical Therapy to *release* information to:**	☐ **I authorize Central Missouri Physical Therapy to obtain information from:**
_____ Name of Person/Facility/Healthcare Provider	_____ Name of Person/Facility/Healthcare Provider
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Phone	_____ Phone/Fax
Please Release: ☐ Medical Records ☐ Billing Records Periods Covering: _____ Method: ☐ Mail ☐ Fax ☐ Email Fax/Email: _____	Please Release: ☐ Medical Records ☐ Billing Records Periods Covering: _____

PURPOSE FOR THIS REQUEST: (Check One)

☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Legal

I hereby release Central Missouri Physical Therapy, LLC, dba Peak Sport and Spine Rehab and all employees from any and all liability, claims or cause of action for providing my medical records, treatment and/or diagnosis, as well as account history to the parties requested. This authorization expires in six (6) months, unless sooner revoked in writing. This authorization is valid for release of information for treatment received prior to the signing of this form.

_____ _____
Patient's Signature Date

_____ _____
Parent/Legal Guardian Signature Relationship to Patient

_____ _____
PEAK Sport and Spine Representative Signature Facility

Revised 1/1/2020