



Professionally staffed by: New York Physical and Occupational Therapy, PLLC

Patient's Name (Please print)

Date

RELEASE OF INFORMATION:

The above Physical Therapy facility may disclose or request all or any part of the patient's record to any person or corporation which is or may be liable under a contract to the facility or the patient or to a family member or employer of the patient for all or part of the facility's charge, including, but not limited to, physical therapy services, insurance companies, Workmen's Compensation/No-Fault carriers, welfare funds, or the patient's employer, or any New York State or Federal agency per current rules and regulations. The Physical Therapy facility has the authority to reject any unreasonable request by an office or institution if such request might violate the patient's right to privacy.

ASSIGNMENT OF BENEFITS:

I hereby assign, and set forth to the above Physical Therapy Center, sufficient monies and/or benefits to which I may be entitled from governmental agencies, insurance carriers, or others who are financially liable for my medical care to cover the costs of the care and treatment rendered to myself or my dependent. I understand I am financially responsible to the above Physical Therapy Center for charges not covered by this authorization.

Signature of Patient or Responsible Party

Date

Witness

Date