Lawrence County

Physical Therapy Institute

Authorization for the use of Photographs and Medical Information

I, _____ herby authorize Lawrence County Physical Therapy Institute to take and use any photographs or medical information for treatment and educational purposes. I give my permission for Lawrence County Physical Therapy Institute to disclose my health information to necessary staff for treatment plan purposes. This authorization extends to copies of said information.

I authorize Lawrence County Physical Therapy Institute to share/release my medical information to my physician or insurance company for appropriate purposes.

I also allow release of my medical records to Lawrence County Physical Therapy Institute.

Date: _____

Patient signature:
_____

Patient printed name:
_____

Witness Signature:
_____

Witness printed name:
_____