SAUNDERS
THERAPY CENTERS

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient's Name (please print): _____

Patient's Date of Birth: _____

I am requesting a copy of my physical therapy records be sent to:

Name: _____

Address: _____

_____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

Concerning my treatment dates from: _____ to _____

Patient's signature: _____ Date: _____

(Under 18 parent or guardian must sign)

Edina
6550 York Ave. S., Ste. 520
Edina, MN 55435
Phone: 952-924-0199
Fax: 952-924-0314

St. Paul
2334 University Ave., Ste. 170
St. Paul, MN 55114
Phone: 651-645-8083
Fax: 651-645-8078

Maple Grove
10900 73rd Ave. N., Ste. 110
Maple Grove, MN 55369
Phone: 763-315-1296
Fax: 763-315-1297

www.saunders- therapy.com