CONSULTATION PHYSICAL THERAPY
of TEXAS
RETURNING YOU TO THE GAME OF LIFE

PATIENT REQUEST FOR RECORDS

DATE: _____

TO: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP:_____

I hereby authorize the release of my medical records and/or imaging or copies of such and request that they be transferred to:

CONSULTATION PHYSICAL THERAPY OF TEXAS, P.C.
427 WEST 20TH STREET, SUITE 207
HOUSTON, TEXAS 77008
FAX: 713-961-0812

_____ _____
DATE OF RECORDS DATE OF BIRTH

_____
PRINT NAME OF PATIENT

_____
PATIENT SIGNATURE