



**AUTHORIZATION FOR RELEASE OF INFORMATION**

I, \_\_\_\_\_ hereby authorize Braun Physical Therapy, Inc. to release and/or obtain any medical or billing records, upon request, to/from an insurance company, legal office, and/or medical facility.

\_\_\_\_\_  
Patient/Guardian Signature                      Date

**PRIVACY PRACTICES ACKNOWLEDGEMENT**

I have received the Notice of Privacy Practices and I have been provided an opportunity to review the document.

\_\_\_\_\_  
Patient/Guardian Signature                      Date

**CONSENT FOR TREATMENT**

I, \_\_\_\_\_ consent and agree to have Braun Physical Therapy, Inc. through its appropriate personnel perform or have performed upon myself or the above named patient the appropriate physical therapy evaluation and treatment procedures necessary for my physical condition for which therapy is sought.

\_\_\_\_\_  
Patient/Guardian Signature                      Date

**CONSENT FOR TREATMENT OF A MINOR**

As parent and/or legal guardian, I authorize Braun Physical Therapy, Inc. to evaluate and treat \_\_\_\_\_ (minor's name) while I am not present.

\_\_\_\_\_  
Parent/Guardian Signature                      Date