If you would like any other person(s) to have access to your medical records, please fill out the following information:

I authorized release of my medical information and records to the following person(s):

_____	_____
Name	Relationship
_____	_____
Name	Relationship

I hereby acknowledge that I have received the Notice of Privacy Practices of:

PKL Physical Therapy & Wellness PC

Effective April 14, 2003

_____	_____
Signature	Date

_____

Print Name