Oakland Physical Therapy, P.C.
26850 Providence Parkway
Suite 365
Novi, MI 48374

RE: AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby authorize any medical professional, hospital, or any other medical-care institution, treating physician, insurance company, group policyholder, attorney, or employer to be provided any medical information acquired in the course of my examination or treatment. This release is valid from the date signed below until such time as revoked, in writing, by the patient.

Signed: _____

Date: _____

RE: AUTHORIZATION TO PAY BENEFITS TO OAKLAND PHYSICAL THERAPY

I hereby authorize payment directly to Oakland Physical Therapy, P.C., of the benefits, otherwise payable to me, for services rendered.

Signed: _____

Date: _____