Restore Resilience Therapy

RELEASE OF INFORMATION

I authorize Margaret Balhoff, PT to release when necessary the medical information contained in my physical therapy record, as requested by insurance companies, in order to process my claim.

I understand that I may revoke any or all of this at any time, by written notice to Margaret Balhoff, PT. A photocopy of my signature here will be as valid as the original.

Date: _____ Signed: _____

Printed Name: _____

Relationship to patient: ___ self ____ parent/guardian ____ other (explain) _____

****

I authorize Margaret Balhoff, PT to release information regarding my diagnosis and treatment, to my physician, or other health care practitioners, as listed below, for the purposes of continuity of care, and follow-up.

I understand that I may revoke any or all of this at any time, by written notice to Margaret Balhoff, PT. A photocopy of my signature here will be as valid as the original.

Physician/practitioner: _____

Physician/practitioner: _____

Parent/Caregiver: _____

Date: _____ Signed: _____

Printed name: _____

Relationship to patient: ___ self ____ parent/guardian ____ other (explain) _____

Margaret Balhoff, PT, MFTc, RCST, SEP
1006 Depot Hill Rd., Broomfield, CO 80020
303-819-8839