**Consent for Release of Medical Information** **Patient/Guardian Initials** _____

**Confirmed appt with patient.**

**I authorize the release of my medical records to Towson Physical Therapy from the following physician(s):**

Physician _____ Physician _____

Address _____ Address _____

City, State Zip _____ City, State Zip _____

**I authorize Towson Physical Therapy to release my medical records to the following people:**

- □ Spouse _____
- □ Child(ren) _____
  _____
  _____
- □ Attorney _____
- □ Other _____

**If you would like to allow anyone else to discuss your bill with Towson Physical Therapy please list them here:**

_____

Patient/Guardian Signature _____ Date _____

Print Name _____

**Consent for Treatment of a Minor** **Patient/Guardian Initials** _____

**As a parent and/or legal guardian, I authorize Towson Physical Therapy to treat the minor patient named below while I am not present.**

Patient Name _____

Parent/Legal Guardian Signature _____ Date _____

Print name_____

**No Show/Cancellation & Returned Check Fee** **Patient/Guardian Initials** _____

We realize circumstances might cause you to miss a scheduled appointment; however, to provide the best care and service to each patient, we ask that you notify us 24 hours in advance to cancel your appointment. We will be more than willing to reschedule your appointment for a different time on the scheduled day OR within 24 hours.

***Please be aware that failure of proper notification could result in a No Show/Cancellation fee of $25.00.***

***There is also a $25.00 charge for all returned checks.***