Healthcare Treatment Authorization for Physical Therapy

Date: [Insert Date]

Patient Name: [Insert Patient Name]

Patient Address: [Insert Patient Address]

City, State, Zip: [Insert City, State, Zip]

Phone Number: [Insert Phone Number]

To Whom It May Concern,

I, [Insert Patient Name], hereby authorize [Insert Physical Therapist's Name or Facility Name] to provide physical therapy treatment as recommended by my physician, Dr. [Insert Physician's Name].

Diagnosis: [Insert Diagnosis]

Treatment Plan: [Insert Treatment Plan Details]

Expected Duration of Treatment: [Insert Duration]

I understand that this authorizes the release of any medical information that may be necessary for my treatment.

Patient Signature: _____ Date: _____

Thank you.