Medical Treatment Authorization for Physical Therapy

Patient's Name: [Patient's Full Name]

Date of Birth: [Patient's Date of Birth]

Address: [Patient's Address]

Insurance Provider: [Insurance Company Name]

Policy Number: [Policy Number]

Provider's Name: [Physical Therapist's Name]

Facility Name: [Physical Therapy Facility Name]

Facility Address: [Facility Address]

Date: [Current Date]

To Whom It May Concern,

I, [Patient's Full Name], hereby authorize [Physical Therapist's Name] at [Physical Therapy Facility Name] to provide necessary physical therapy treatment for my condition as outlined in my medical records.

This authorization allows the above-mentioned provider to render treatment and to obtain any necessary diagnostic tests in the course of medical evaluation and treatment.

Please process this authorization as soon as possible. If further information or clarification is needed, do not hesitate to reach out to my primary care physician listed below:

Primary Care Physician: [Doctor's Name]
Office Phone: [Doctor's Phone Number]
Address: [Doctor's Office Address]

Thank you for your prompt attention to this matter.

Sincerely,

[Patient's Signature]

[Printed Name]