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RELEASE OF INFORMATION TO PHYSICIAN

Your physician is the medical representative responsible for coordination of your total care. Therefore it is appropriate for him or her to be aware of the therapy taking place under my care. With your permission, I would like to communicate basic treatment information to your physician.

Client Name _____ Date of Birth _____

Please DO NOT contact my physician: _____

Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____ Date: _____