Authorization to Referring Doctor

Doctor's Name:_____

Address:_____

City: _____ State:_____Zip:_____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

I, _____, hereby authorize Health Sphere Wellness Center, LLC to disclose protected health information to my referring doctor as named above. Any information released to my doctor will be for, but not limited to, obtaining Physical Therapy Orders.

I understand that if specific P.H.I. is needed, I will sign a separate release form to specify the information needed.

I understand that I may revoke this authorization at any time. In doing so, I will send a written notification to Health Sphere Wellness Center, LLC at 5054 Thoroughbred Lane, Brentwood, TN 37027.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient/Legal Guardian Date