

Ullucci Sports Medicine & Physical Therapy, Inc.

I, _____, hereby authorize the release any and all
(please print patient's name here)
records pertaining to my injury which occurred on _____.
(please print date of injury)

This release specifically will allow Ullucci Sports Medicine & Physical Therapy, Inc. to provide the company or individual named below a hardcopy, facsimile or PDF of all my medical records (Evaluation, Reevaluation, Treatment Records, general notes and visit history) as well as the billing and payment history for this injury.

This information should be provided to:

(Name) _____

(Address) _____

(Phone) _____ (Fax) _____

This authorization is good for 30 days from the date below, unless I provide Ullucci Sports Medicine & Physical Therapy, Inc. a formal written cancellation.

Patient's Authorizing signature including minors

today's date

Parent/Guardian signature if patient is a minor

today's date

(Sorry we must have both patient and parent/guardian signatures before we can legally process your request)

Please print Parent/Guardian name

Staff Witness Signature

Staff Witness Printed Name

(modified 2/10/2008)

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