



Physical Therapy
Sports Medicine
Fitness

**AUTHORIZATION FOR RELEASE OF INFORMATION TO
PROACTIVE FITNESS**

To: _____

I, the undersigned patient/guardian, hereby the release of protected health information from the medical records of:

Patient: _____

Birthdate: _____

SSN: _____

Party To Whom Records Should Be Sent:

ProActive Fitness
5040 Snapfinger Woods Drive Suite 205
Decatur, Georgia 30035
Phone: (678)205-5736
Fax: (678)205-5739

This authorization for Release of Information is in force:

_____ until revoked by me in writing or

_____ until _____ (Date)

I further authorize that a copy of this medical authorization may be used in lieu of the original.

Signature of Patient/Guardian

Print Name

Witness

Date