I,\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby consent to and authorize all therapy treatments, independent or in conjunction with the judgement of my attending physician, maybe considered necessary and/or advisable for the diagnosis and/or treatment of the patient named above at Sports and OrthopaedicTherapy Services, LLC (SP.OR.T.S.). I authorize SP.OR.T.S. to release information, verbal and written, contained in my medical record to my insurance company, case managers, assignees, and/or beneficiaries as it relates to my treatment and or payment.

Printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (PATIENT OR LEGAL GUARDIAN MUST SIGN IF PATIENT IS UNDER 18 YEARS OF AGE)

Relationship to Patient: SELF PARENT LEGAL GU