DANIEL ARYEH, P.T. LLC

I hearby authorize Daniel Aryeh, PT, LLC ("the practice") to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize the Practice to release any and all medical records concerning my care to any physician, hospital or other health care professional providing care to me at any time. Additionally, I authorize the Pracrice to release any and all medical records concerning my care to Medicare, Medicaid, any insurance company, third party administrator, or managed-care company.

Patient Signature Date

Printed Name Date of Birth

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff of the Practice to discuss your condition with members of the family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waved.

_____ I do not authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

_____ I authorize the Practice to verbally release any or all information concerning my medical care to the following individuals.

Name Realtionship to Patient

Name Realtionship to Patient

Patient Signature Date

Witness Date