Release of Medical Information

I, the undersigned, hereby grant permission to release my medical information and authorize payment of health insurance benefits to Mackarey and Mackarey Physical Therapy Consultants, LLC. I also understand that I am fully responsible for payment of Deductibles and Co-insurance and any charges that are incurred and not covered by my health insurance.

MEDICARE PATIENTS: "I request that payment of authorized Medicare benefits be made either to me or on my behalf to: Mackarey and Mackarey Physical Therapy Consultants, LLC, for any services furnished me by physician or supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and it's agents any information needed to determine these benefits and payment for related services."

Signed: _____

Date: _____

_____

Please Print Patient Name