

Sacramento Spine & Physical Therapy

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RELEASE OF RECORDS

I authorize Sacramento Spine and Physical Therapy to:

1. Release any and all medical records, reports, history, diagnosis, treatment, radiology reports, and all other records of any kind or nature, for services rendered in connection with my care and treatment to insurance or medical personnel involved with this care. (Expiration if desired: _____)
2. If it is necessary to obtain documents from my Sacramento Spine and Physical Therapy File, I consent to the acceptance of a photocopy; hereof in lieu of the original documents.
3. Obtain copies of my medical records in connection with care at their facility.

Patient's Name: _____ SSN: _____

Patient's Signature: _____ Date: _____

E-mail address: _____

Use of Roseville Health & Wellness Center Inc. (RHWC) and/or California Family Fitness (CFF) during physical therapy

As a participant with Sacramento Spine & Physical Therapy (SSPT), I understand that the Roseville Health & Wellness Center Inc, (RHWC) and/or California Family Fitness (CFF) will not be responsible for any loss, claim, or damage incurred with respect to any negligence of SSPT. I understand that SSPT is fully responsible for my care and I may request their general and professional liability insurance face sheets to reference coverage. In the event I should sustain any injuries or damages while under the care of SSPT, I hereby agree to present any and all such claims to SSPT. This is not intended to waive any of my legal rights; however, it is intended to make SSPT the primary party liable for claims mentioned herein. I hereby assume the risks associated with lost, stolen, or damaged automobile, personal property, money, or other valuables brought to the facility or left on the premises, including the locker room.

Patient's Signature: _____ Date: _____

Medications/Supplements

Please list name, dosage, frequency, route (oral, topical, etc). Attach list if needed.
