ADVANCED
physical medicine
& therapy, ltd.
350 W. Kensington Rd. #102
Mt Prospect, IL 60056
(847) 222-9060 www.apmt.us

Medical Office Providing Records:

_____
Name

_____
Street Address

_____
City, State, Zip Code

I hereby request and authorise you, your employees and ages to furnish the person(s) listed below or anyone designated in writing by him/her/them, all records and reposts including x-rays and photostatic copies, abstracts or excerpts of all record and any other information he/she/they may request related to any examination, treatment or opinion concerning any condition that I may have had in the past, now have, or may have in the future.

_____Patient records of myself _____MRI/CT Report _____Original X-Rays of myself

_____Copies of X-Rays of myself _____Patient Records of my son/daughter

_____Permission to discuss medical treatment and billing with a family member

_____Other:_____

_____

Please forward the reports and information request to:

_____
Name

_____
Street Address

_____
City, State, Zip Code

_____
Signature

_____
Print Name Date of Birth

_____
Street Address

_____
City, State, Zip Code

_____
Date