BACK ON TRACK PHYSICAL MEDICINE

1914 9TH Avenue
Port Arthur, TX 77642
409-982-1043 ▪ 409-982-1232 (fax)

AUTHORIZATION/CONSENT FOR TREATMENT

Patient Name: _____ Phone:_____
Address_____ City/State/Zip: _____
SS#: _____ Date of Birth: _____

I do hereby authorize Back On Track Physical Medicine to provide those diagnostic, preventative and therapeutic services which are deemed necessary for my health care.

I do hereby grant Back On Track Physical Medicine my permission to obtain information regarding my medical records. This includes x-rays, records, reports, and laboratory findings.

_____ _____ _____
Patient Signature Print Name Date

AUTHORIZATION/CONSENT FOR TREATMENT OF A MINOR CHILD

I do hereby authorize Back On Track Physical Medicine to provide those diagnostic, preventative and therapeutic services which are deemed necessary for my Minor Child's health care.

I do hereby grant Back On Track Physical Medicine my permission to obtain information regarding my Minor Child's medical records. This includes x-rays, records, reports, and laboratory findings.

Please forward all correspondence to the above listed address. If you have any questions or need any additional information please do not hesitate to contact our office. Thank you for your cooperation.

_____ _____
Parent Signature Date

_____ _____
Parent Name (print) Name of Minor Child