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CONSENT OF TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____

I hereby authorize Med Diagnostic Rehab of South Florida through its appropriate personnel, to perform or have performed upon me or the above named patient, appropriate assessment and treatment procedures relating to the diagnosis stated by my referring physician.

I further authorize Med Diagnostic Rehab of South Florida to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Signature:_____ Date: _____

Relationship to patient: Self ☐ Guardian ☐ Other ☐