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Aberdeen, NJ 07747
Phone: (732) 290-1080
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AUTHORIZATION TO RELEASE MEDICAL RECORDS

Date: _____

I, _____ authorize Cornerstone Physical Therapy, Inc. to
release all my son's/ daughter's records to:

I acknowledge that I have been informed of the Provider Notice of Practices which is
located in the reception area of this facility.

Signature (Parent or Guardian)

Print Name