BREVARD THERAPY
&PHYSICAL MEDICINE

I, _____ give Brevard Therapy and Physical Medicine permission to discuss my condition and share my medical records with the following people:

Name: _____

Relationship: _____

Phone number: _____

Name: _____

Relationship: _____

Phone number: _____

Name: _____

Relationship: _____

Phone number: _____

Name: _____

Relationship: _____

Phone number: _____

Signature: _____