**Quality Care Rehabilitation Professionals**
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# PATIENT OF RESPONSIBLE PARTY AUTHORIZATION FORM

Patient Name: _____

Date of Birth: _____

I, as the patient or responsible party, authorize any holder of medical or other information about the patient named above, to release to Social Security Administration or its intermediaries or other insurance carriers any information for this or a related Medical Claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits for PHYSICAL THERAPY, OCCUPATIONAL THERAPY and SPEECH THERAPY treatments be made to the Provider.

Printed Name: _____

Patient's Signature: _____

Date: _____

**If the patient is the responsible party, but their signature is not legible, please provide signature by a witness and the date signed.**

Witnessed By: _____

Signature: _____

Date: _____

**If the Responsible Party is someone other than the patient, please sign here to authorize treatment.**

Printed Name: _____

Signature: _____

Date: _____

Relationship to Patient: _____