HEALTH INFORMATION RELEASE FORM

In order to assist you in receiving your health information from Peoples Physical Therapy, please complete this form.

I authorize the person(s) listed below to have access to any and all of my health information, billing and health insurance information. Peoples Physical Therapy is permitted to share any medical information with them, including test results and information disclosed during office visits.

Persons authorized to receive my medical information (full name and phone number):

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____
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You may notify me or the parties listed above with appointment reminders and other information regarding my health information as follows:

_________ Message on answering machine (Phone number) _________________________

_________ Message on work voicemail (Phone number) _________________________

_________ Message on cell phone (Phone number) _________________________

I understand and direct that this authorization will remain in effect until it is revoked by me in writing.

Do you want to be reminded of appointments by:

_________ Text Cell Service Provider:___________________

_________ Email _________________________________

_________ Telephone

____
Patient – Print Name

____
Patient – Signature

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Date

Notice of Information Practices is available to read upon request