

PATIENT'S REPRESENTATIVE AUTHORIZATION

In accordance with new federal regulations we are not allowed to discuss or even acknowledge that you are a patient of Colleyville/Trophy Club Physical Therapy without your expressed written consent. If there is anyone (i.e... spouse, parent, neighbor, etc.) you think might ever have a need to discuss your medical condition, your therapy, your appointment, or your financial account please list them below. This will prevent us from having to get your written consent each time they call to handle matters on your behalf.

Mark each purpose for which you are authorizing your protected health information to be used and/or disclosed to your representative.

Discussion of financial account

Discussion of medical status

Discussion of scheduling appointments

Other _____

Select one of the following:

This authorization will expire on the following date: _____

This authorization will expire when I have been discharged from therapy and all financial matters are settled.

I understand that I may revoke this authorization at any time by giving written notice to the front desk staff. However, I understand that I may not revoke this authorization for any actions taken before receipt of my written notice to revoke this authorization.

1) Personal Representative's Name: _____

Relationship to patient: _____

2) Additional Representative's Name: _____

Relationship to patient: _____

Patient's Name: _____ Date of Birth: _____

Telephone: _____ Alt Telephone: _____

Patient's Signature _____

Date _____