COLORADO CENTER
FOR PHYSICAL THERAPY

Neuromuscular Therapy • Pelvic Floor Pain & Rehabilitation • Orthopedic Rehabilitation

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION (PHI)

I authorize the practice to discuss appointment dates, times, location, medical history, diagnosis, treatment, prognosis, financial, insurance and billing information with those listed below. I understand that my or my child's healthcare provider will use his/her judgment in sharing this information in order to foster continuity of care. The release of copies of medical records will require a signed HIPAA-compliant authorization. This permission will be considered on-going until I indicate otherwise in writing.

PHI may be released to the following individuals:

1. _____
2. _____
3. _____
4. _____

Yes ___ No ___ CCPT Staff have my permission to share my or my child's personal health information with family members or others who are in the room with me/us during the appointment.

CCPT Staff have my permission to leave messages concerning treatment/appointments on my:

___ Home VM/answering machine — Home Phone #: _____
___ Cell Phone Voice Message — Cell Phone #: _____
___ Cell Phone Text Message — Cell Phone #: _____
___ Work VM/answering machine — Work Phone #: _____
___ E-mail (encrypted/non-encrypted) — E-mail Address: _____
___ NO INFORMATION: I do not authorize the release of any verbal, text or email information (other than appointment reminders to the numbers that I have provided).

_____ Print Name of Patient

_____ *Print Name of Authorized Representative

_____ Patient/Authorized Rep. Signature

_____ Date Signed

*Authorized Rep. Authority to act on the Patient's behalf:
___ Parent/legal guardian ___ Power of Attorney

* Evidence of authority must be provided and on file with CCPT.

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