

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 | |
| during the appointment. | nbers or others who are in the room with me/us |
| CCP1 Staff have my permission to leave messa | ages 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 Address: |
| | e the release of any verbal, text or email information to the numbers that I have provided). |
| Print Name of Patient | *Print Name of Authorized Representative |
| Patient/Authorized Rep. Signature | Date Signed |
| ⁴ Authorized Rep. Authority to act on the Patie Parent/legal guardian Power of | |
| Fyidence of authority must be provided and | on file with CCPT |

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

