



PERMISSION TO DISCLOSE INFORMATION TO THOSE INVOLVED IN MY CARE

NAME _____
(PLEASE PRINT)

DOB _____

PHYSICIAN _____

I hereby allow SALINA PHYSICAL THERAPY, LC to disclose the following Protected Health Information:

- Appointment times and dates
- Other Health Information
- Billing Information

To the following people because they are involved with my health care or payment:

- Spouse: _____
- Child/Children: _____
- Family Friend: _____
- Other: _____

In the following forms of communication:

- Home telephone: _____
- Work telephone: _____
- Cell phone: _____
- E-mail: _____
- Other: _____

Patient Signature

Date

Valid until revoked by signature in written form and submitted to: SALINA PHYSICAL THERAPY LC Privacy Officer, 521-A S. Santa Fe Ave., Salina, KS 67401