171 S. Lake Ave.
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sPorT plus physical therapy, LLC

*"**S**pecializing in **P**atient **O**riented **R**ehabilitative **T**reatment"*
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AUTHORIZATION FOR ORAL RELEASE OF MEDICAL INFORMATION TO FAMILY OR FRIENDS

I, _____, _____ authorize
(Name of Patient) (Date of Birth)

sPorT plus physical therapy, LLC to orally disclose protected health information relating to my identity, diagnosis, prognosis, or treatment to the individual (s) listed below:

_____, _____, _____
(Name) (Relationship to Patient) (Telephone #)

_____, _____, _____
(Name) (Relationship to Patient) (Telephone #)

_____, _____, _____
(Name) (Relationship to Patient) (Telephone #)

_____, _____, _____
(Name) (Relationship to Patient) (Telephone #)

If you prefer the above section be blank, please draw an [X] over the blank lines to indicate this as your choice.

The purpose for this disclosure is to give sPorT plus physical therapy, LLC authorization to orally disclose, to those listed above, information regarding my medical care.

The authorization for disclosure of information is valid for _____ years (to be completed by the patient) from the date of signature. If the number of years is left blank, this authorization will expire 2 years from the date of signature. This authorization is revocable in writing at any time except to the extent that disclosure has already taken place.

I understand that information disclosed as a result of this authorization may further be used or disclosed by someone who obtains that information and therefore may no longer be protected by federal privacy laws.

sPorT plus physical therapy, LLC will not condition treatment on the individual's providing the authorization.

Authorization **MUST BE SIGNED BY THE PATIENT.** Parent or legal guardian is to sign if patient is a minor or is mentally or physically incompetent.

_____
(Signature of Patient) (Date)

_____
(Signature of Parent/Legal Guardian) (Relationship to Patient)