POTTSVILLE AREA PHYSICAL THERAPY SERVICES
CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

By signing this consent, you authorize Pottsville Area Physical Therapy Services to disclose your protected health information to the individuals listed below (if you wish to restrict the disclosure, you should submit a request in writing to the Privacy Officer of this practice for consideration):

☐ Only Myself

☐ Spouse/Children/Other

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

Name:_____ Relationship_____

This practice does not take responsibility for any disclosures made by the individual(s) listed above. Please contact the Privacy Officer of this practice if you should wish to terminate or change any information related to the above named individual(s).

I have reviewed this consent form. I give my permission to this practice, Pottsville Area Physical Therapy Services, to use and disclose my health information in accordance with the privacy standards.

_____

Print Patient Name

_____

Signature of Patient/Parent/Legal Guardian or Patient Representative) Relationship to Patient

_____

Date