PHOENIX
PHYSICAL THERAPY

HIPAA COMPLIANT RELEASE TO TALK TO OTHERS

Due to the HIPAA Act, we are not allowed to speak with anyone in regards to your treatment and or financial obligations in regards to Phoenix Physical Therapy unless we have your signed consent.

_____ _____ - _____ - _____

Patient printed name SSN

Please fill in the following if we are allowed to speak with the following individuals:

_____	_____	_____
Name of person	**Relationship**	**Telephone number**
_____	_____	_____
Name of person	**Relationship**	**Telephone number**

It is okay to leave a message on my home and/or cell phone: ____ Yes ____ No

_____ _____

Signature of patient/responsible party **Date**

<u>PLEASE DO NOT SIGN THIS NOW</u>. This notice can be rescinded at anytime in the future by signing the date you want it rescinded. Only sign this when you want to change and/or delete the names above.

_____ _____

Patient Signature **Date**

Edited 3/28/12