PRESSLER PHYSICAL THERAPY CLINIC

DESIGNATED INDIVIDUALS AUTHORIZATION FORM AND COMMUNICATION

1. I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information.

Authorized Designees:

Name: ________________________________ Relationship: __________________________

Name: ________________________________ Relationship: __________________________

Name: ________________________________ Relationship: __________________________

Name: ________________________________ Relationship: __________________________

2. Please print the address where you would like correspondence from our office to be sent if other than your home.

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3. Please print the telephone number where you want to receive calls about appointments etc. other than your home phone number.

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4. Can confidential messages be left on your answering machine?

YES_______________ NO________________

____
Patient Name

____
Patient Signature

____
Date