TRINITY
PHYSICAL THERAPY

Individuals authorized to request/receive information

I hereby authorize one or all of the following parties designated below to request and/or receive information concerning my Protected Patient Information in regards to my treatment(s), payment(s), quality, and/or administrative operations. I understand that the designated party(s) must be verified before the release of my information.

Authorized party:

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

Name:_____Relationship_____

Patient Name: _____ Legal Guardian: _____

Patient Signature (or Legal Guardian): _____ Today's Date:_____