PARK MEADOWS
CENTER FOR MOVEMENT

CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

1. I grant permission to Park Meadows Center for Movement to disclose health information for the following individual:

   Patient Name: _____

2. How do you like to get *routine* messages? Letter ___ Email ___ Phone ___

3. **When is it Okay to leave a message about your treatment**
   - ☐ Never
   - ☐ On my voicemail at home: Number_____
   - ☐ On my voicemail at work: Number_____
   - ☐ On my mobile phone: Number_____

4. **With whom may we discuss your whole-body health?**
   ☐ No one ☐ Any of the people listed below

   _____/_____/_____
   Name Relationship Phone number

   _____/_____/_____
   Name Relationship Phone number

   Primary Care Doctor: _____
   Specialist: _____
   Physical Therapist: _____
   Other: _____

5. **What is okay to discuss with those noted above:**
   - ☐ Any information about the patient's treatment*
   - ☐ Only that I attend classes
   - ☐ Only that I was seen for physical therapy, but no specifics
   - ☐ Other

*I understand this may include detailed personal medical information including medical services to be provided. This consent will expire when revoked by the patient/representative or on the date the minor becomes an adult under state law.

_____ _____ _____
Patient or Authorized Signature Print Name Date

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