CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

1. I grant permission to Therapeutic Relief 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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