



CONSENT TO DISCLOSE PERSONAL HEALTH INFORMATION

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

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
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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, but no specifics

*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