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

______________________/______________________/______________________
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, 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