ENCHANTED LAKE PHYSICAL THERAPY

Authorization for Release of Personal Health Information (PHI) to Authorized Person(s) by Patient

---

It is our policy not to release confidential medical information to family members or friends, except for parents and/or legal guardians, if the patient is a minor, or as otherwise permitted by the Health Insurance Portability and Accountability Act of 1966 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members or other persons, please complete the following information.

Patient Name: _____ Date of Birth: _____

☐ **Check this box if you DO NOT want your Personal Health Information (PHI) to be provided to family members or other persons. Print your name and date of birth above, then sign at the bottom.**

I hereby authorize Enchanted Lake Physical Therapy and/or Business Associates to disclose the following (please check the appropriate box(s) below):

- ☐ My Personal Health Information, such as information regarding my condition and/or treatment.
- ☐ My Financial Information such as billing, payment, and updating my insurance information.
- ☐ Other:_____

To the following authorized person(s):

1. _____ _____
   Print Name of Authorized Person #1 Relationship
   _____ _____
   Address Contact Phone Number
   _____
   Email or Alternative Method of Communication

2. _____ _____
   Print Name of Authorized Person #2 Relationship
   _____ _____
   Address Contact Phone Number
   _____
   Email or Alternative Method of Communication

This authorization is voluntary. I may revoke this authorization in writing, and it will not affect any actions already taken by Enchanted Lake Physical Therapy and/ or Business Associates based upon this authorization.

_____ _____ _____
Signature of Patient (or Legal Representative) Relationship to Patient Date