Volk Physical Therapy & Sports Medicine

Authorization for Volk Physical Therapy to Release Appointment Information

While being treated as a patient at Volk Physical Therapy and Sports Medicine, I may require the use of a/an:

☐ Interpreter ☐ Sign Language Transliterator ☐ Transportation Service Company ☐ Other

In the event one of these services is provided for me during my treatment and in order to assist in the coordination of my scheduled appointments with these various entities or with other specified individuals, I hereby consent to the release and disclosure of my appointment times and dates to:

Name: _____
(If unknown at this time, please write "TBD")

Address: _____ City: _____

State: _____ Zip Code: _____ Fax: _____ Phone: _____

Dates of Treatment Beginning: _____

This protected health information is disclosed for the following purpose: _____

_____ Authorization expiration date: _____

I understand that the information outlined in this release will be disclosed according to the instructions for this release within two (2) business days of Volk Physical Therapy having received this release authorization. I understand that I am free to revoke this release authorization at any time by notifying the practice in writing. I also understand that the information disclosed under this release is subject to re-disclosure and no longer protected by the Privacy Regulations (45 C.F.R. 164).

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient: _____

_____ _____
(Signature of Patient or Patient Representative) (Date)