CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

1. **I grant permission to Park Meadows Pilates and Physical Therapy to disclose health information of the following individual as specified below:**

   Patient Name: _____

2. **I authorize the information to be disclosed as specified below:**
   - ○ Non-urgent communication (circle Preference): Letter Phone Secure Email Fax#:_____
   - ○ On my voicemail/answering machine at home_____(specify phone#)
   - ○ On my voicemail/answering machine at work_____(specify phone #)
   - ○ On my voicemail on cell phone _____(specify phone#)

   To Health care provider: _____

   To the following family member(s) or other person(s):

   _____/_____/_____
   Name Relationship Phone number

   _____/_____/_____
   Name Relationship Phone number

3. **The type and amount of information to be disclosed is as follows:**
   - ○ Any information about the patient's treatment*
   - ○ Other (specify):_____

   *I understand that this may include detailed personal medical information including medical services to be provided.

_____ _____ _____
Signature of Patient or Authorized Personal Representative Print Name Date

(Please attach applicable legal documentation of authority)

This consent form will expire when revoked by the patient/representative or on the date the minor becomes an adult under state law