CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

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

   Patient Name: _____

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

We want to keep your healthcare providers informed about your health and wellness. Pilates is an integral part of your musculoskeletal whole-body health. Please list the provider names that we can share information with.

Primary Care Doctor: _____

Specialist:_____

Physical Therapist:_____

Other:_____

To the following family member or other person:

_____/_____/_____
Name Relationship Phone number

3. **The type and amount of information to be disclosed is as follows:**
   - o Any information about the patient's treatment*
   - o Only that I attend classes
   - o Only that I was seen for physical therapy, but no specifics
   - o Other (specify):_____

*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