Provident Physical Therapy

Designated Individuals Authorization Form

I hereby authorize one or all of the designated parties below to request and receive the release of any protected health information regarding my treatment, payment or administrative operations related to treatment and payment. I understand that the identity of designated parties must be verified before the release of any information. If you do not authorize any parties below, please "x" through section below.

Patient Name:_____

Authorized Designees:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

_____ _____

Patient's Signature Date

Acknowledgement of Notice of Privacy Practices

Provident Physical Therapy reserves the right to modify the privacy practices outlined in the notice.

( ) I have received a copy of the notice of privacy practices for Provident Physical Therapy.

_____

Name of Patient (Print)

_____

Signature of Patient

_____

Date

(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient