



Timberlane

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.

Authorized Designees:

Name: _____ (Emergency Contact)
Relationship: _____

Name: _____
Relationship: _____

Name: _____
Relationship: _____

Name: _____
Relationship: _____

Patient Name

Patient Signature

Date