HIPPA Disclosure Form

Patient Name: _____ Date: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Email: _____

Would you like our correspondence with you marked confidential? _____ Yes _____ No

May we identify ourselves over the phone? ____ Yes ____ No

May we leave a message on your home phone: ____ Yes ____ No

May we leave a message on your Cell phone: ____ Yes ____ No

I, _____, hereby authorize Complete Rehab and Sports PT to release my medical information and or to discuss any and all medical information/financial information to the following physicians and family members (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc). This authorization is good for 1 year from signing and if there is a change to whom we may speak or send medical records patient will come in and sign a new HIPPA form. (PLEASE DO NOT LIST YOURSELF BELOW, LIST A FAMILY MEMBER OR DOCTOR)

Name: _____ DOB: _____ Relation: _____

Name: _____ DOB: _____ Relation: _____

Name: _____ DOB: _____ Relation: _____

Patient Signature: _____

Parent/Guardian Signature: _____