Shoreline
PHYSICAL THERAPY
sport & spine specialists

Authorization to Disclose Personal Health Information

Patient Name: _____

Date of Birth: _____

Names of persons eligible to receive information on my behalf:

_____ Relation _____

_____ Relation _____

_____ Relation _____

_____ Relation _____

COMPLETE ONLY IF LIMITED INFORMATION

□ Information about Insurance only

□ Information about Services Rendered only

□ Information about Account Balance/Bills only

CHECK BOX INDICATING HOW LONG AUTHORIZATION IS VALID:

□ Disclose my personal health information indefinitely

□ Disclose my personal health information for a specified period only, beginning (mm/dd/yy) _____ and ending (mm/dd/yy) _____.

_____ _____

Authorized Signature Date