South Whidbey Physical Therapy
& Sports Clinic

Authorization to Leave Personal Health Information By Alternate Means

Patient name:_____ Date of Birth: _____

(Please check all that apply). Please keep in mind, if you want a phone call, text or email reminder, you will need to check off the appropriate circle below.

◯ We may leave a detailed message on voicemail at home #:_____

◯ We may leave a detailed voicemail on cellular phone: #_____

◯ We may leave a detailed text message on your cellular phone: #_____

◯ We may leave a detailed message by email:_____

◯ We can discuss/leave information with your partner, friend or relative:

☐ No
☐ Yes: Please print their name(s) and contact information below

Signature:_____ Date:_____

The following person(s) can inquire, discuss account, pick up records, etc.., and take messages regarding my health information: Please include any physicians, friends, or relatives you may allow to take part in caring for your health and health information). We will not disclose your record to others without your permission, or unless the law authorizes or compels us to do so.

These permissions will remain in effect until you give us written notice of any changes.

1. _____ Relationship:_____ Contact #:_____
2. _____ Relationship:_____ Contact #:_____
3. _____ Relationship:_____ Contact #:_____
4. _____ Relationship:_____ Contact #:_____

HIPAA: By Signing this form I acknowledge that I have received a copy of the HIPAA "Notice of Information Practices" from South Whidbey Physical Therapy & Sports Clinic and I understand it completely.
CONSENT: By signing this form, I agree and give consent for South Whidbey Physical Therapy & Sports Clinic to furnish physical therapy care and treatment considered necessary and proper in diagnosing and/or treating my physical condition.

_____ _____

Signature of Patient or Responsible Party **Date**