

UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF ALLIED HEALTH PROFESSIONS

DEPARTMENT OF
PHYSICAL THERAPY

PHYSICAL THERAPY CLINIC

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(Please print and bring this form to your first appointment)

PERSONAL REPRESENTATIVES PHI MAY BE SHARED WITH

I authorize the University of South Alabama Physical Therapy Clinic to share Protected Health Information (PHI) with the follow individuals regarding the care and treatment of (patient name).

Name of Individual

Relationship to Patient

Name of Individual

Relationship to Patient

Name of Individual

Relationship to Patient

Name of Individual

Relationship to Patient

Signature of Patient/Patient Representative

Date