FOOTHILLS
PHYSICAL THERAPY GROUP

Designated Individuals Authorization Form

I hereby authorize 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.

_____

Name, Relationship, Contact Number

_____

Name, Relationship, Contact Number

_____

Name, Relationship, Contact Number

Notice of Privacy Practices Acknowledged

I have been given an opportunity to review, ask questions about and I understand Foothills Physical Therapy Group's Notice of Privacy Practices. (see copy attached, and also available on our website and at the front desk)

_____ _____

Patient or Legal Guardian's Signature. First, Last Name Date