Dee Physical Therapy
166 Athletic Drive
Shelburne, Vermont 05482

Protected Health Information Release Authorization
Request for Use/or Disclosure by Others

***Patient Full Name:*_________________________________*Date of Birth:*_______________**

I authorize Dee Physical Therapy to disclose my protected health information to (other entity). This release will enable Dee PT the ability to speak to Spouse/Partner, Parents of adult Children, Children to Parents, etc.:

Spouse/Partner:

Name:_________________________________DOB____________

Parent: Mother Father Guardian Care Giver Other____________________

Name:__________________________________Phone #____________________
Please Print

- ✓ I understand this authorization may be revoked in writing and delivered to Dee Physical Therapy at any time.

________________________ ____
Date Signature of individual/Patient

EXPIRATION DATE: This authorization has no expiration date unless cancelled in writing by patient.

COPY PROVIDED: Dee Physical Therapy will provide a copy of this authorization, when signed, to the subject individual. This information has been disclosed to you from records whose confidentiality is protected by federal law.