St. John Physical Therapy, LLC

COMMUNICATION AUTHORIZATION FORM

Patient Name: ______________________ SSN: ______________________________

When it comes to your medical treatment, we strive to communicate with you in as timely and professional a manner as possible. There are certain occasions when family members, friends, or others might be involved in your care, as a patient you will want St. John Physical Therapy to be able to communicate directly with them. In order to protect the privacy of your personal health information, please share with us the names of any other people with whom we can discuss your care and share your protected health information.

Please list below any other people with whom you authorize our office to discuss aspects related to your care.

Name: ____________________________ Relation to patient: ___________________
Name: ____________________________ Relation to patient: ___________________
Name: ____________________________ Relation to patient: ___________________

COMMUNICATION AUTHORIZATION FOR STUDENT ATHLETES

Student Athlete's Name____

School Name: ____

Date of Injury: ____

Please list below names of trainers, coaches, and school officials that you will allow access to discuss and share student's records.

Names:

____

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Signatures:

____ __________________________________

Authorized Representative's Printed Name   Authorized Representative Signature

Date: _____________________________________

____

SJPT Representative

Date: _____________________________________