HAND TO HAND THERAPY CLINIC, LLC

DESIGNATED INDIVIDUALS AUTHORIZATION FORM

AUTHORIZED DESIGNEES:

I hereby authorize one or all of 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. I understand that the identity of designated parties must be verified before the release of any information.

Name: Relationship: ____

Name: Relationship: ____

Patient Signature__________________________________ Date_____________________

TELEPHONE CONTACT WITH PATIENTS

Hand to Hand Therapy Clinic contacts patients for a variety of reasons, including scheduling and follow up for treatments. If you would like to restrict the way in which we contact you (e.g., do not leave a message on answer machine; do not provide information to others who might answer your phone at home or work) please provide this information below.

PATIENTS INSTRUCTIONS TO STAFF REGARDING TELEPHONE CONTACT:

It is permissible to contact me at the telephone numbers below & leave voice message

○ Home _________________○ Work_________________○ Cell____________________

It is permissible to leave a message with other people who may answer the telephone numbers checked below:

○ Home phone ○ Work phone ○ Cell phone

Patient Signature_________________________________ Date_____________________

***REMINDERS FOR APPOINTMENTS**

Would you like a reminder email? □Yes □ No Email:________________________