Lake Superior Physical Therapy

Authorization To Discuss Health Information

I, ____, born on ________________________________,
authorize Lake Superior Physical Therapy to discuss health, medical and billing related information with the following person or persons in my absence and without my prior consent:

____ ________________________________
Name **Relationship**

____ ________________________________
Name **Relationship**

____ ________________________________
Name **Relationship**

____ ________________________________
Name **Relationship**

This authorization shall be in effect from _________________________ to __________________________,
Date Date
or until I advise Lake Superior Physical Therapy to rescind or restrict this authorization.

____ ________________________________
Patient Signature **Date**