College Park Physical Therapy

Telephone Communications Form

Please complete ALL information fields below.

Disclosures to friends or family members

I give permission for my protected health information to be disclosed for the purpose of communicating results, findings, and care decisions made by family members and others listed below, and/or if I am not available and they are acting on my behalf:

Name	Relationship	Contact Number

Above list remains valid until College Park physical Therapy is notified in writing of change(s).

Often our patients are not available when we call them and would like to leave a detailed telephone message regarding Medical (i.e. lab/testing results) or billing* information when possible. We will communicate the minimum amount of necessary information appropriate to keep you informed in your healthcare partnership with us. In order to protect your privacy, we need your written permission where we can leave a detailed voice mail regarding your medical or billing information or appointment.

I, _____ , (please print name) give College Park Physical Therapy staff/providers permission to leave telephone messages regarding my care/billing using one or more of the following options below until I rescind this directive in writing.

Patient print name: _____ DOB: _____

Patient/Parent/Guardian signature: _____ Date: _____

Please check and complete for each selection we may use:

- ☐ Home answering machine Number: _____
- ☐ Work Phone Number: _____
- ☐ CellPhone Number: _____
- ☐ Spouse Name _____ Number: _____
- ☐ Other Name _____ Number: _____

If you are completing this form for a minor/child under the age of 18, please list the following:

Mother's name: _____ Father's name: _____

*If you are 18 or covered under a parent/guardian's insurance plan, the owner of the policy may receive billing information with specifics regarding your care at College Park Physical Therapy.