UNIVERSITY OF SOUTH ALABAMA

COLLEGE OF ALLIED HEALTH PROFESSIONS

DEPARTMENT OF
PHYSICAL THERAPY

PHYSICAL THERAPY CLINIC

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(Please print and bring this form to your first appointment)

PERSONAL REPRESENTATIVES PHI MAY BE SHARED WITH

I authorize the University of South Alabama Physical Therapy Clinic to share Protected Health Information (PHI) with the follow individuals regarding the care and treatment of ____ (patient name).

Name of Individual	Relationship to Patient
Name of Individual	Relationship to Patient
Name of Individual	Relationship to Patient
Name of Individual	Relationship to Patient
Signature of Patient/Patient Representative	Date