



Communication Authorization

I, \_\_\_\_\_, hereby authorize Bird Physical Therapy to communicate confidential information regarding my appointments, plan of care, treatment status, and billing information to the following individual(s).

Name:

Relationship:

Phone #:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_