



Kevin Bird, M.S., P.T. | Bria Livingston, D.P.T | Julianne Fisher, D.P.T, ATC | Jessica Lemus, D.P.T.

Communication Authorization

Patient Name: _____ DOB: _____

I, _____ hereby authorize Bird Physical Therapy to communicate confidential information regarding my appointment scheduling, plan of care, treatment status, and/or billing information to the following individual(s).

<u>NAME:</u>	<u>RELATIONSHIP:</u>	<u>PHONE #:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Signature: _____

Date: _____

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