



BIRD PHYSICAL THERAPY

Kevin Bird, M.S., P.T. | 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).

NAME:

RELATIONSHIP:

PHONE #:

Signature: _____

Date: _____

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