

**Dee Physical Therapy**  
**23 San Remo Drive**  
**So. Burlington, Vermont 05403**

**Protected Health Information Release Authorization**  
**Request for Use/or Disclosure by Others**

**Patient Full Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

I authorize Dee Physical Therapy to disclose my protected health information to (other entity). This release will enable Dee PT the ability to speak to Spouse/Partner, Parents of adult Children, Children to Parents, etc.:

**Spouse/Partner:**

Name: \_\_\_\_\_ DOB \_\_\_\_\_

**Parent:** Mother    Father    Guardian    Care Giver    Other \_\_\_\_\_

Name: \_\_\_\_\_ Phone # \_\_\_\_\_  
Please Print

- I understand this authorization may be revoked in writing and delivered to Dee Physical Therapy at any time.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of individual/Patient

**EXPIRATION DATE:** This authorization has no expiration date unless cancelled in writing by patient.

**COPY PROVIDED:** Dee Physical Therapy will provide a copy of this authorization, when signed, to the subject individual. This information has been disclosed to you from records whose confidentiality is protected by federal law.