

Diamond Physical Therapy
1406 E. Algonquin Rd.
Algonquin, IL 60102
(847) 854-0196 Fax (847) 854-0197

Consent for Release and Use of Confidential Information

I, _____, hereby give my consent to
(Name of Patient or Authorized Agent)

Diamond Physical Therapy to use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in the patient record of _____.
(Patient's Name)

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to Diamond Physical Therapy. I also understand that I will not be able to revoke this consent in cases where Diamond Physical Therapy has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the Diamond Physical Therapy Office.

Signed: _____ Date: _____

If you are not the patient, please specify your relationship to the patient:
