Comprehensive Therapy Services

Speech Therapy • Occupational Therapy • Physical Therapy

Patient Authorization for Contact
Please print all information, then sign and date the form at the bottom of the page.

Patient Name (please print): ________________________________

Purpose of Request: I authorize Comprehensive Therapy Services to disclose my protected health information in the following manner:

Mobile Phone #: __________________________________

_____ Leave detailed messages on voicemail.

_____ Leave messages with only call-back request only on voicemail.

Email Address: __________________________________

_____ Communicate information via email address.

Home Phone #: __________________________________

_____ Leave detailed messages on voicemail.

_____ Leave messages with only call-back request only on voicemail.

Other Phone #: ________________________________

_____ Leave detailed messages on voicemail.

_____ Leave messages with only call-back request only on voicemail.

Expiration or Termination of Authorization: This authorization will remain in effect until terminated by patient, the patient's personal representative, or another individual of legal entity authorized to do so by court order or law.

Right to revoke or terminate: As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Contact. This can be done in person or by mailing a request to the address above.

_____________________________________ _________________
Patient or Guardian Signature Date

2201 N. Central Expwy. Suite 110 Richardson, TX 75080
Dallas 214-265-1819 Fax 214-373-9530