

Physical therapy for the body, mind and spirit
SPIRIT WINDS
physical therapy

Consent to Leave Voice/Text Messages and/or Email

Thank you for choosing Spirit Winds! Recent changes in the law require us to have your express consent to email/text you. Completing this form will also help us communicate with you in the ways you prefer.

Completion of this document authorizes the disclosure and/or use of health information about you. The purpose is to give permission to leave certain health information on your voice or text messaging service. Failure to provide all information requested may invalidate this authorization.

Name of patient: _____
(Please print)

USE AND DISCLOSURE OF HEALTH INFORMATION

I hereby authorize **Spirit Winds Physical Therapy, Inc.** to call/text me to relay information about my appointment(s) including, but not limited to, reminder texts/calls and/or account payment, balances, or cost estimates, to the following phone numbers/email:

Mobile: _____
Home: _____
Email: _____

EXPIRATION:

This authorization/permission shall not expire; however, I understand that at any time I reserve the right to change my mind and revoke this privilege to Spirit Winds Physical Therapy, Inc. Should I decide to revoke this permission I will notify the front office with both a verbal and written notice. Or I may send this revision to:

Spirit Winds Physical Therapy, Inc 1257 Laurel Lane San Luis Obispo, CA 93401
Initial _____

MY RIGHTS:

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment with Spirit Winds Physical Therapy, Inc.

Signature: _____ Date: _____