Valley Regional Hospital

Compassion | Accountability | Respect | Excellence | Service

I, _____ give permission for
(Name of legal guardian/DPOA)

_____ , to receive rehabilitation services including physical
(Name of patient)

therapy, occupational therapy, speech therapy, and/or audiology at Valley Regional Hospital.

Patient Name: _____ DOB: _____

Legal Guardian/DPOA Name: _____

Legal Guardian/DPOA Signature: _____ Date: _____

Witness: _____ Date: _____

*This permission is valid for 1 year after date of initiation, and must be must be renewed for services requested after 1 year.