CONSENT TO RELEASE / OBTAIN INFORMATION

AUTHORIZATION TO COMMUNICATE INFORMATION CONTAINED IN THE FILE OF:

FIRST NAME

LAST NAME (AT BIRTH)

#FILE NUMBER

ADDRESS

CITY

PROVINCE

POSTAL CODE

HEALTH INSURANCE NUMBER

DATE OF BIRTH (AAAA/MM/JJ)

I or duly authorized representative, , authorize **PHYSIO**OUTAOUAIS to send copies or give a verbal report of my file to the individual(s) / organization(s) named:

○ DOCTOR(S) ○ EMPLOYER ○ CSST, WSIBT, SAAQ ○ OTHER :

I, or duly authorized representative, , authorize the establishment,

to release to **PHYSIO**OUTAOUAIS the following information :

on this date (DATE)

I have read the above authorization(s) and indicate my consent by my signature. This authorization shall be valid for 12 months from this date.

SIGNATURE OF CLIENT (OR DULY AUTHORIZED REPRESENTATIVE)

YEAR / MONTH / DAY

SIGNATURE OF WITNESS

YEAR / MONTH / DAY

PHYSIO OUTAOUAIS
MÉDECINE DU SPORT

Please print the completed form and bring it with you to the clinic at your next appointment.

PHYSIOOUTAOUAIS.CA