AUTHORIZATION AND CONSENT TO RELEASE OF HEALTH INFORMATION

To Whom It May Concern:

I, the undersigned, consent to and authorize the release of all information contained in my health records (*including hospital records, physiotherapist office records, pharmaceutical prescription records and patient billing information)*.

Print Full Name of Patient (s)_____

Patient's Health Card # (s)_____

Patient's Date of Birth (s)_____

Print Full Name of Person Giving Consent_____

Information to be Released to:

_____

_____

_____

_____ _____

Patient's Signature ***Name of Witness (*print)**

OR

Address: _____

Legally authorized Representative*

_____

_____

_____

(Signature)

Phone Number: _____

_____

(Print Name)

Relationship to patient (please state)

Signature of Witness: _____

_____

(*includes: executor or administrator of an estate, next of kin or legal guardian)

_____ _____

Date Date

Nova Scotia College of Physiotherapists
PO Box 22
Smith's Cove, NS
B0S 1S0

Phone: (902) 454-0158
1-866-225-1060
Fax: (902) 245-3134
registrar@nsphysio.com
www.nsphysio.com