AUTHORIZATION AND CONSENT TO RELEASE OF INFORMATION

To Whom It May Concern:

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

Print Full Name of Patient (s)_____

Patient's Health Card # (s)_____

Patient's Date of Birth (s)_____

Print Full Name of Person Making Complaint_____

to the Nova Scotia College of Physiotherapists. This will also provide consent for the Nova Scotia College of Physiotherapists to request, receive, photocopy and disseminate this information as necessary for the investigation of the above in accordance with the disciplinary process.

If the complainant is someone other than the patient <u>or</u> the patient's legally authorized representative, complete the following:

*I hereby authorize*_____ *to pursue this complaint on my*
(Print complainant's name)
behalf and to receive all information in relation to the investigation of the complaint.

_____
Patient's Signature

<u>OR</u>

Legally authorized Representative*

_____
(Signature)

_____
(Print Name)

_____
Relationship to patient (please state)
(*includes: executor or administrator of an estate, next of kin or legal guardian)

_____
Date

_____
***Name of Witness (*print)**

_____
Address
_____

_____

_____
Phone Number

_____
Signature of Witness

_____
Date