Sexsmith Physiotherapy Inc.
PO Box 158 Sexsmith, AB T0H 3C0
Phone: 780-568-2032
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Consent Form For Release of Medical Information

(Adapted from Health *Information Act: Guidelines and Practices*, Alberta Health and Wellness, 2001)

_____	_____/_____/_____	_____
(Name of Patient)	Birth date (day/month/year)	Alberta Health Care Number

I authorize release of my medical information from:

Dr. _____
or
Hospital/Imaging Facility _____

to **SEXSMITH PHYSIOTHERAPY INC.,** for the purpose of providing physiotherapy assessment and treatment.

Please send the following report(s) to Sexsmith Physiotherapy Inc.:

- ❑ X-Ray
- ❑ CT Scan
- ❑ MRI
- ❑ Bone Scan
- ❑ Surgical Report
- ❑ Other

Area(s) of Body:_____

I understand why I have been asked to disclose my individually identifying information, and am aware of the risks and benefits of consenting, or refusing to consent, to the disclosure of my individually identifying health information.

I understand that, under section 58 (2) of the *Health Information Act*, my express wishes must be considered and I have the right to indicate any portion of my health information that I wish to be kept confidential by my physician and not disclosed to others. I may revoke my consent at any time.

Date:
_____
Day / Month / Year

_____	_____
Patient Signature (or Authorized Representative)	Witness Signature