Laurel Health
Physiotherapy & Wellness

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# CONSENT TO COMMUNICATE WITH PHYSICIAN

| PATIENT INFORMATION | |
|---|---|
| Patient Name: | Date of Birth (mm/dd/yyyy): |

| PHYSICIAN INFORMATION |
|---|
| Physician Name: |

*Please fill in the following information if available*

| Physician Address: | | | Postal Code: |
|---|---|---|---|
| City: | Province: | Physician Fax: | Physician Phone: |

## CONSENT

I, patient named above, authorize my therapist to communicate with the physician named above regarding my care at Laurel Health Physiotherapy & Wellness.

______________________________ Patient Signature

______________________________ Date Signed (mm/dd/yyyy)

*(Laurel Health Physiotherapy & Wellness respects your privacy. We do not sell, rent, loan or transfer any personal informationregarding our clients to any third parties.)*