Laurel Health
Physiotherapy & Wellness

1347 20 Street NW, Edmonton – T6T2R7
Phone: +1 5877090085, info@laurelphysio.com

CONSENT TO DISCLOSE HEALTH INFORMATION

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

INDIVIDUAL/ORGANIZATION THAT PATIENT WANTS HEALTH INFORMATION DISCLOSED TO

Individual/Organization Name:

**Please fill in the following information about the individual/organization if available*

Address:			Postal Code:
City:	Province:	Email Address:	Phone Number:

WHAT HEALTH INFORMATION DO YOU WANT DISCLOSED

**Disclosure may be comprehensive or specific. If specific, please provide the details of the health information you want disclosed*

CONSENT

I authorize my health practitioner at Laurel Health Physiotherapy & Wellness to disclose the health information described above to the individual/organization identified above. I understand the risks and benefits of consenting or refusing to consent. I understand that I may revoke this consent in writing at any time.

_____ _____

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.)