**CONSENT to the RELEASE of INFORMATION**

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give my informed consent to the Clinic to release information with respect to my care to the following:

1. Insurer: To disclose medical and/or other information with the relevant third party (indicate ICBC, WSBC, extended health insurance, etc.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Yes 🞎 No \_\_\_\_\_\_ Initials

1. Medical Professional(s): To disclose medical information to and obtain medical information from my Physician, Specialists or other treating therapists for the purpose(s) of assessing or providing treatment services.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ 🞎 Yes 🞎 No \_\_\_\_\_\_ Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ \_ 🞎 Yes 🞎 No \_\_\_\_\_\_ Initials

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_ 🞎 Yes 🞎 No \_\_\_\_\_\_ Initials

1. Employer or their Representative: To discuss return to work information with my Employer or their Representative (per the limitations of this discussion as reviewed with my physiotherapist)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Yes 🞎 No \_\_\_\_\_\_ Initials

1. Lawyer: to disclose medical or other information to my Lawyer (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 🞎 Yes 🞎 No \_\_\_\_\_\_ Initials
2. Other (explain) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

🞎 Yes 🞎 No \_\_\_\_\_\_ Initials

I understand that my consent may be amended or revoked in whole or in part at any time by providing written notice to the Clinic as outlined in the clinic’s Privacy Policy, and that revoking consent may have additional consequences such as withdrawal of treatment or the decline of a payment by a third-party payer.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Client Name Signature Date