EAST HILLS PHYSIOTHERAPY

Today's Date: (mm/dd/yr) _____

Medical Authorization Permission

Att: Medical Records Dept.

Clinic/Hospital/physician/law firm/ employer

Patient's name:

AHS #:

Date of birth:

Date of Injury Occurred:

I, _____, hereby authorize East Hills Physiotherapy & Massage to Release and Request copies of any or all information from Physicians, Diagnostic Centers, Insurance Companies, Employers, and Law Firms with respect to my care.

Requesting / Releasing: Related to my injury due to: ☐ MVA ☐ WCB ☐ General pain/injury

Diagnostic Report: ☐ x-ray ☐ Ultrasound ☐ MRI ☐ Other _____

Diagnostic report date: _____ (If available) Body Part(s): _____

Reports: ☐ MVA Forms ☐ WCB ☐ Treatment Charting Notes

OTHER:

_____

_____

*** This authority will continue until withdrawn, by me, in writing. ***

Patient signature: _____ Date: _____

EASTHILLS PHYSIOTHERAPY and MASSAGE CLINIC
Unit 303, 409 East Hills Blvd SE, Calgary AB, T2A 4X7
Tel: (403) 207-1960
Fax: (587) 333-0082
www.easthillsphysio.com