Physio 4 U

459-23rd St Brandon, MB R7B 1V7
Ph. (204)725-4066 Fax (204)725-0012

AUTHORIZATION FOR CLINICAL INFORMATION

From: Physio 4U
459 23rd Street
Brandon, MB R7B 1V7

Re: Name: _____

DOB: _____

MHSC: _____

Doctor: _____

I hereby authorize the release of the following records, pertaining to my physiotherapy treatment to my physiotherapist at Physio 4U. By signing, I agree to allow the staff of Physio 4U to provide and receive written reports or documentation on my behalf.

_____ _____
Patient/Parent/Guardian Date

Please check off if you have had any of the following tests done and provide the date and body area

___ X-rays

___ CT Scan

___ Bone Density

___ Bone Scan

___ MRI

___ Post Operative Report

___ Consulting Physician reports

___ Other: _____

_____

*If you are unsure of the exact date, please indicate the year and possible month.

Revised August 10, 2017