CONSENT TO RELEASE CLIENT / PATIENT INFORMATION

I, ______________________________ authorize Meridian Physiotherapy, Dr. Andrew

Buser and Meridian Physiotherapy Associate Practitioners to: _____X____(send) _____ X_______(receive) the following ____X_____(to)

____X______(from) the following agencies or people:

Name: __Dr. Trevor Buser____

Name: ____

Information to be released: __Patient files including intake, history, and treatments___________

____

____

The above information will be used for the following purposes:
_X_ Planning appropriate treatment or program
_X_ Continuing appropriate treatment or program
_X_ Determining eligibility for benefits or program
_X_ Case review
_X_ Updating files
___ Other (specify)

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information.

Client's / Patient's signature: ____ Date: ______

Parent/guardian signature: ____ Date: ______

Witness (if client or patient is unable to sign): ____________________________Date: ______

Person informing client / patient of rights: ______________________________ Date: ______