CONSENT TO RELEASE CLIENT / PATIENT INFORMATION

I, _____ authorize Meridian Physiotherapy and Dr. Andrew

Buser to: _____(send) _____(receive) the following _____(to)

_____(from) the following agencies or people:

Name: _____

Name: _____

Information to be released:

_____

_____

_____

The above information will be used for the following purposes:
___ Planning appropriate treatment or program
___ Continuing appropriate treatment or program
___ Determining eligibility for benefits or program
___ Case review
___ 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: _____