REBALANCE
SPORTS MEDICINE
rebalancetoronto.com

CONSENT TO COMMUNICATE WITH PHYSICIAN

PATIENT INFORMATION	
Patient Name:	Date of Birth (mm/dd/yyyy):

PHYSICIAN INFORMATION			
Physician Name:			
**Please fill in the following information if available*			
Physician Address:			Postal Code:
City:	Province:	Physician Fax:	Physician Phone:

CONSENT

I, patient named above, authorize my therapist to communicate with the physician named above regarding my care at Rebalance Sports Medicine.

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Patient Signature Date Signed (mm/dd/yyyy)