REBALANCE
SPORTS MEDICINE
rebalancetoronto.com

CONSENT TO DISCLOSE HEALTH INFORMATION

PATIENT INFORMATION

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

INDIVIDUAL/ORGANIZATION THAT PATIENT WANTS HEALTH INFORMATION DISCLOSED TO

Individual/Organization Name:

**Please fill in the following information about the individual/organization if available*

Address:			Postal Code:
City:	Province:	Email Address:	Phone Number:

WHAT HEALTH INFORMATION DO YOU WANT DISCLOSED

**Disclosure may be comprehensive or specific. If specific, please provide the details of the health information you want disclosed*

CONSENT

I authorize my health practitioner at Rebalance Sports Medicine to disclose the health information described above to the individual/organization identified above. I understand the risks and benefits of consenting or refusing to consent. I understand that I may revoke this consent in writing at any time.

_____ _____

Patient Signature Date Signed (mm/dd/yyyy)