REBALANCE
SPORTS MEDICINE
rebalancetoronto.com

CONSENT TO RELEASE OF PERSONAL HEALTH INFORMATION TO A THIRD PARTY

PATIENT INFORMATION			
Last Name:	First Name and Initial(s):	Gender: ❑ M ❑ F	Date of Birth (mm/dd/yyyy):
Street Address:			Postal Code:
City:	Province:	Email:	
Health Card #:		Version Code:	Expiry Date (mm/dd/yyyy):

NAME OF PERSON/FACILITY WHERE RECORDS ARE BEING SENT			
❑Records are being released to the patient listed above (choose delivery method)			
Recipient/Facility Receiving Records:			Method of Delivery: ❑Pick up ❑Delivery ❑Fax ❑Email
Street Address:			Postal Code:
City:	Province:	Fax:	

PAYMENT

A $40 - $180 administrative charge will be applied to release medical records to any recipient or facility for all four methods of delivery indicated above. If pick up option is selected, picture ID is required.

CONSENT

I, the patient (or legal guardian) named above, fully understand the above and agree to abide by the payment policy. I hereby authorize Rebalance Sports Medicine to release all medical records to the recipient named in section 2 to the address named in section 2.

_____ _____

Patient or Guardian Signature | Print Name of Witness

_____ _____

Witness Signature | Date Signed (mm/dd/yyyy)