

Today's Date (mm/dd/yy): _____

MEDICAL AUTHORIZATION PERMISSION

Attn: Medical Records Department

Clinic / Hospital / Physician / Law Firm / Employer

Patient's Name: _____

AHS #: _____

Date of Birth: _____

Date of Injury: _____

I, _____, hereby authorize East Hills Physiotherapy & Massage to release and request copies of any or all information from physicians, diagnostic centers, insurance companies, employers, and law firms with respect to my care.

Requesting / Releasing related to my injury due to: ☐ MVA ☐ WCB ☐ General pain/injury

Diagnostic Report: ☐ X-Ray ☐ Ultrasound ☐ MRI ☐ Other: _____

Diagnostic report date: _____ Body Part(s): _____
(if available)

Reports: ☐ MVA Forms ☐ WCB Forms ☐ Treatment Charting Notes

OTHER: _____

***** This authority will continue until withdrawn, by me, in writing. *****

Patient Signature: _____ Date: _____