110 Yonge St/ Suite 905/ Toronto, ON / M5C 1T4
[P] 416-777-9999 [F] 1-866-338-1236
[E] info@rebalancetoronto.com
www.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.

_____ _____

Patient Signature Date Signed (mm/dd/yyyy)