

CONSENT TO RELEASE OF PERSONAL HEALTH INFORMATION TO A THIRD PARTY

PATIENT INFORMATION			
Last Name:	First Name and Initial(s):	Gender: <input type="checkbox"/> M <input type="checkbox"/> 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			
<input type="checkbox"/> Records are being released to the patient listed above (choose delivery method)			
Recipient/Facility Receiving Records:		Method of Delivery: <input type="checkbox"/> Pick up <input type="checkbox"/> Delivery <input type="checkbox"/> Fax <input type="checkbox"/> Email	
Street Address:		Postal Code:	
City:	Province:	Fax:	

PAYMENT
A \$40 - \$100 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)