

**AUTHORIZATION AND CONSENT TO RELEASE
OF INFORMATION**

To Whom It May Concern:

I, the undersigned consent and authorize the release of information contained in any health records (including hospital records, physiotherapist office records, pharmaceutical prescription records and patient billing information) concerning the patient (s).

Print Full Name of Patient (s) _____

Patient's Health Card # (s) _____

Patient's Date of Birth (s) _____

Print Full Name of Person Making Complaint _____

to the Nova Scotia College of Physiotherapists. This will also provide consent for the Nova Scotia College of Physiotherapists to request, receive, photocopy and disseminate this information as necessary for the investigation of the above in accordance with the disciplinary process.

If the complainant is someone other than the patient or the patient's legally authorized representative, complete the following:

*I hereby authorize _____ to pursue this complaint on my
(Print complainant's name)
behalf and to receive all information in relation to the investigation of the complaint.*

Patient's Signature

Name of Witness (print)

OR

Address

Legally authorized Representative*

(Signature)

(Print Name)

Phone Number

Relationship to patient (please state)
***(*includes: executor or administrator of an estate,
next of kin or legal guardian)***

Signature of Witness

Date

Date