Box 2410 Humboldt, SK S0K 2A0
Ph: (306) 682-6610; Fax: (306) 682 6636

CONSENT TO RELEASE/OBTAIN INFORMATION

I, _____, herby authorize Humboldt Therapy Centre to:

- Release copies or give a verbal report of my assessment, treatment plan, interim progress report(s), discharge plan and follow-up reports as applicable, to all individuals or agencies listed below

and/or

- Contact any of the individual(s)/organization(s) named for the purpose of obtaining information regarding my injury, impairment, disability, functional or vocational needs.

_____ Physician

_____ Other individual(s) (WCB, SGI, GWL etc.)

_____ Chiropractor

_____ Rehabilitation Management Co./Case Worker

_____ Physiotherapist

_____ Employer/name of contact

I have read the above authorization(s) and indicate my consent by my signature. This authorization will be valid twelve (12) months from this date.

_____ Signature of Client

_____ Date

_____ Signature of Parent or Legal Guardian

_____ Signature of Witness