physiotherapykingston
spinalrehabcentre

CONSENT FOR EXAMINATION AND RELEASE OF INFORMATION
By Law We Must Obtain This Important Information For Our Records

DATE: _____

Name: _____

Address: _____

City: _____**Postal Code:** _____**Telephone: (home)** _____

(work) _____

(mobile) _____

Email Address:_____

Date of Birth: (DD/MM/YY) _____

.....

	Agree	**Do Not Agree**
1. This document confirms that I, _____ authorize Physiotherapy Kingston to conduct a thorough physiotherapy assessment and receive treatment at their clinic.	☐	☐
2. Part of the treatment may involve a physiotherapy assistant/aid as described by the College of Physiotherapy of Ontario. He/She has been trained to perform modalities on clients after the physiotherapist assesses and determines the course of treatment.	☐	☐
3. At different times of the year we have physiotherapy students as part of their clinical placements and I consent to their involvement in my case.	☐	☐
4. I understand that I will be charged for treatments if I do not provide **24 hours notice of cancellation**.	☐	☐
5. I also permit them to obtain & review copies of any medical, hospital, clinic, x-ray, or other records related to my medical condition. Copies of this authorization may be used as proof of my consent of the above mentioned areas.	☐	☐
I have read this document and thoroughly understand it.	☐	☐

Signature:_____