



**AUTHORIZATION FOR RELEASE OF PATIENT MEDICAL INFORMATION**

I, \_\_\_\_\_, SN \_\_\_\_\_ hereby authorize the release of the following medical information:

**Physiotherapy chart**

From: Sooke Evergreen Physiotherapy Inc.

#3 - 6726 West Coast Road,

PO Box 520, Sooke, BC V9Z 1N5

Phone 250-642-4911, 250-642-5522 Fax 250-642-4905 email sookephysio@shaw.ca

To: Canadian Forces Health Services Centre (Pacific) Attn: Physiotherapy Section

PO Box 17000, Stn Forces

Victoria, BC V9A 7N2

Phone (250) 363-4446

Fax (250) 363-4441

From the records of:

\_\_\_\_\_  
(Name of patient, include surname and all given names)

I consent to the use of this information the by the authorized recipient only for the purpose of:

**Inclusion into my medical file.**

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date