SUMMIT
PHYSIOTHERAPY

MEDICAL AUTHORIZATION FORM

This form allows your therapist to obtain relevant health care information, most commonly Xray, MRI or OR reports important to your care and rehabilitation.

Alberta Personal Health Card #: ___ ___ ___ ___ ___ - ___ ___ ___ ___

I, _____ , of _____ ,
(Print First and Last Name) (City of Residence)
Alberta, do hereby authorize you to release to **SUMMIT PHYSIOTHERAPY LTD.**, any and all information they may require pertaining to my physical condition, including, but not limited to all records, progress notes, reports of diagnostic tests, X-rays and medical opinions.

Date: _____

Client Signature: _____

Witness: _____

To be filled by parent/guardian if applicable:

_____ _____ _____
Print Name Parent/Guardian Signature Date

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