Beddington Physiotherapy

Information Authorization Permission

Patients Name: ____

Birth Date: _______________________ Alberta Health Care Number: ________________

Signature: _______________________ Date: ____________________________________

Witness: _______________________ Date: ____________________________________

I, _______________________________________, hereby authorize Beddington Physiotherapy to **Release and Request** copies of any or all information **From or To** Physicians, Diagnostic Center, Insurance company, Employers and Law Firms with respect to my care the following information:

ATTN:	Name	Sign for consent
Lawyer		
Physician		
Insurance		
Employer		

All requested medical records in connection with my Physical Therapy condition and injuries such as

☐ X-Ray

☐ Ultrasound

☐ MRI

☐ Other, please specify ___________________________

☐ MVA Forms (AB forms, approval, or extension letters)

To

Beddington Physiotherapy

#206-8120 Beddington Blvd NW

Calgary, T3K 2A8

Phone: 403-474-9636

Fax: 403-474-9637