

AUTHORIZATION TO PROVIDE MEDICAL INFORMATION

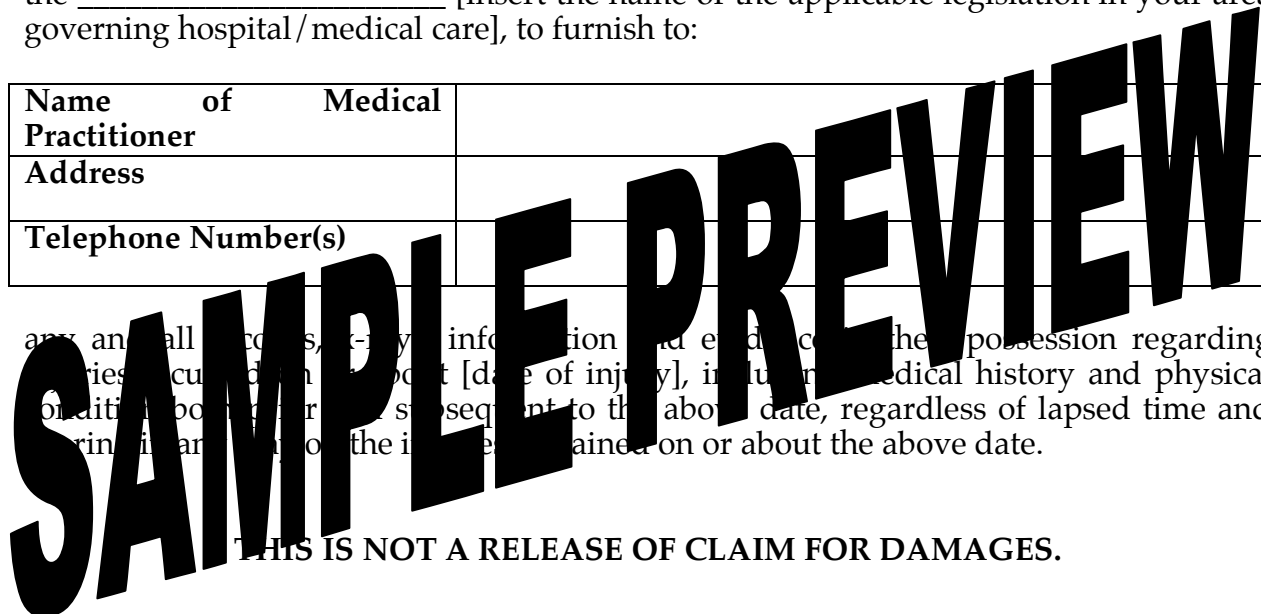
Date: _____

TO WHOM IT MAY CONCERN:

I, _____ [patient name] OR I, _____ [name], parent/guardian of _____ [patient name], a minor, or administrator of the estate of _____ [patient name], hereby consent to and authorize every medical practitioner, chiropractor, physiotherapist, dentist, medical insurer, ambulance owner and the employees of every hospital as defined in the _____ [insert the name of the applicable legislation in your area governing hospital/medical care], to furnish to:

Name of Medical Practitioner	
Address	
Telephone Number(s)	

any and all records, reports, information and evidence in their possession regarding injuries incurred on or about [date of injury], including medical history and physical condition both prior to and subsequent to the above date, regardless of lapsed time and printing and of the information obtained on or about the above date.



THIS IS NOT A RELEASE OF CLAIM FOR DAMAGES.

Name of patient (please print clearly)	
Date of birth	
Authorized signature	
Address	
Telephone Number(s)	