VOR Vestibular & Orthopaedic Rehabilitation
55 Erb Street East, Unit 303, Waterloo ON N2J 4K8
Ph: 519-208-0150 | Fx: 226-647-1905

RELEASE OF INFORMATION

Patient Name: ____ Date of Birth: ______________
dd / mm / yyyy

To facilitate my care, I authorize Vestibular & Orthopaedic Rehabilitation (VOR Physiotherapy) or any of its representatives to receive and review copies of my hospital, medical or other related health records pertaining to my injuries and treatment. I give permission for VOR to provide information verbally or in writing about my assessment, treatment, and functional abilities to the Health Care Professionals described below:

Health Care Professionals I provide consent to release and exchange information, either verbal or written:

1) _______________________________________(Family Doctor) Phone: ____________________

2) _______________________________________(Specialists if applicable)Phone: ____________________

I understand that VOR Physiotherapy will send reports to the doctor who referred me to the clinic and/or my family doctor.

VOR Physiotherapy may release information to other health professionals, insurance representatives, lawyers or employers who may be involved in my rehabilitative care. This may occur when I have authorized the insurer, lawyer, employer, or others to do so and a signed release is sent to VOR Physiotherapy. I understand that fees for reports or telephone consultations may apply.

I understand that I may request a copy of my assessment, progress, and discharge report at no charge and distribute the report to my doctors, other health professionals, insurance representatives, lawyers, or employers as I deem appropriate.

Extended Health Benefits Provider #1 (if applicable)	
Name of Insured	
Policy Number	ID/Member #
Allowance for Physiotherapy ($)	

Extended Health Benefits Provider #2 (if applicable)	
Name of Insured	
Policy Number	ID/Member #
Allowance for Physiotherapy ($)	

Signature of Client: ____________________________ Date: ________________

Signature of Witness: ___________________________ Date: ________________