Patient Consent to Release Personal Health Information

The Coxwell physiotherapy centre (o/a West Aurora Physiotherapy Center) is requesting your consent to release to the Ministry of Health and Long Term Care (the "ministry"), the information you provide on this form, as well as information about the physiotherapy service(s) you receive from the physiotherapy providers in the Coxwell Physiotherapy centre (o/a West Aurora Physiotherapy Center) as of the date of your signature. The ministry requires this information to verify that the services were provided to you as a patient of the Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center) and to pay Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center) for providing the services.

If you choose not to consent to the release of this information, the ministry will not pay for the services that you receive, and you will be required to pay Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center) directly for the services. Your consent will end when:

1. You withdraw your consent by advising Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center) at the telephone number or address below.
2. You no longer qualify for Ontario Health Insurance Plan (OHIP) Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center)
3. You cease to be a patient of the physiotherapy providers in the

If you have questions about this consent form please call the Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center) at 905-841-7126

Or write to:

Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center)
126 Wellington St W
Aurora, ON - L4G 2N9
Email: info@Coxwellphysio.com.

I consent to the Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center) releasing the following information to the Ministry of Health and Long-Term Care ("ministry") as of the date indicated below:

Patient Information: (Please Print)

1. Last Name: _____ First Name: _____ Middle Name: _____
2. Date of Birth: _____
3. Health Card: _____

4. A description of the physiotherapy service(s) provided to me by physiotherapy providers at my physiotherapy clinic as of the date indicated below, and
5. The date(s) on which these service(s) are provided to me.

I understand that I can withdraw my consent by contacting the Coxwell physiotherapy centre. (o/a West Aurora Physiotherapy Center) at 905-841-7126 and that if I withdraw my consent I will be required to pay the Clinic directly for services that the Clinic provides to me as a patient following the withdrawal of consent.Patient Signature:

☒ I am signing on my behalf
☐ I am signing as a parent, or person who is lawfully entitled to give or refuse consent, on behalf of a child who is under 16
☐ I am signing as the guardian of the person, or attorney for personal care of an incapable adult

Name: (please print) _____ Signature: _____

Date: (YYYY-MM-DD) _____

Please provide your contact telephone number if you are signing on behalf of a child, or an incapable adult: _____