Patient Consent to Release Personal Health Information

The Dixie Physiotherapy & Wellness (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 Dixie Physiotherapy & Wellness (o/a West Au- - rora 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 Dixie Physiotherapy & Wellness. (o/a West Aurora Physiotherapy Center) and to pay Dixie Physiotherapy & Wellness. (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 Dixie Physiotherapy & Wellness (o/a West Aurora Physiotherapy Center) directly for the services. Your consent will end when:

1. You withdraw your consent by advising Dixie Physiotherapy & Wellness. (o/a West Aurora Physiotherapy Center) at the telephone number or address below.
2. You no longer qualify for Ontario Health Insurance Plan (OHIP) Dixie Physiotherapy & Wellness. (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 Dixie Physiotherapy & Wellness. (o/a West Aurora Physio- - therapy Center) at 905-625-9295

Or write to:

Dixie Physiotherapy & Wellness. (o/a West Aurora Physiotherapy Center)
1420 Burnhamthorpe Rd. E., #225
Mississauga, Ontario L4X 2Z9 Canada
Email: info@dixiephysio.com

I consent to the Dixie Physiotherapy & Wellness. (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 Dixie Physiotherapy & Wellness. (o/a West Aurora Physio- - therapy Center) at 905-625-9295 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: _____