

CONSENT FORM

I hereby authorize Brady Physiotherapy to release medical information to my family physician, specialist, insurance company, employer, lawyer or their representative pertaining to the injuries for which I am being treated.

I hereby consent to the following treatment:

A diagnosis regarding my condition will be given by a Registered Physiotherapist along with a treatment plan. The treatment will be prescribed with the goal of restoring and maintaining physical activity.

I will expect to be told about the following by a Registered Physiotherapist:

- What the treatment is
- Who will be providing the treatment
- The reasons why I should have the treatment
- The alternatives to having the treatment
- The important effects, risks and side-effects of the treatment
- What would happen if I do not have the treatment

The Physiotherapist will ensure that I understand the explanation and have no further questions. My consent is voluntary.

Date

Patient Signature

Patient Name (print)

Witness Signature

Witness Name (print)