Wellington Hand Clinic

CONSENT TO RELEASE MEDICAL INFORMATION

Due to privacy legislation, your signed consent will enable us to communicate with your doctor, employer, insurance company, or lawyer if applicable. Your signature also allows us to receive test results (X-ray, US, MRI) requested by your doctor.

If your appointments are being billed to WSIB, we are **required** to send information to WSIB and in some cases to your employer to receive payment for your visits.

Please initial beside those with whom you give us permission to share information.

- € Doctor
- € Employer
- € Insurance Company
- € WSIB
- € Lawyer
- € _____

Name (please print)_____ Witness_____

Signature_____ Date_____

Date_____