

Consent for Collection, Use and Release of Personal Information

I, _____ give D'Arcy Bain Physiotherapy my consent to release information to, and to obtain information from the following individuals with respect to my care by report, letter, phone, fax, email, or direct communication:

- Family Physician, Referring Physician, Associated Specialists*
- Workers Compensation Board of Manitoba*
- Manitoba Public Insurance*
- Private Insurance Provider*
- Hospitals or Tertiary care facilities*
- Employer*

I authorize D'Arcy Bain Physiotherapy to request diagnostic imaging (i.e., X-ray, CT scans, MRI) and or reports, any appropriate diagnostic information, or operative reports related to my medical condition.

Signature: _____

Your Choices

You may access and correct your personal health records or withdraw your consent for some of the above uses and disclosures (subject to legal exceptions) by contacting us. A fee may be charged to access your personal health records in order to account for accessing off-site storage, copying fees and re-filing.

Important Information

D'Arcy Bain Physiotherapy collects, uses, discloses, retains and disposes of your personal information in compliance with federal and provincial privacy legislation and provincial college licensing regulations. All staff members who come in contact with your personal information have signed a confidentiality form and have been trained in the appropriate use and protection of your information. Everyone who performs services for us will protect your privacy and only use your personal health information for the purposes you have consented to.

Name (print) _____
 Address _____
 Date of Birth _____

Signature _____ **Date (M/D/Y)** _____

**This authorization shall continue until revoked in writing or for a period of 2 years. A photocopy of this authorization will serve in its stead.*
**This form is in accordance with PIPEDA (Personal Information Protection and Electronic Documents Act) and PHIA (Personal Health Information Act)*