Name of Kinesiologist

Name of company

Address
City, Prov, Postal Code
Phone
E-Mail
Website

Name of Client:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

M.V.C. Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL AUTHORIZATION**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_the undersigned, DO HEREBY AUTHORIZE you to release to Name of Kinesiologist, title - Kinesiologist, address, any and all information that may be required in connection with my physical condition and injuries from the \_\_\_\_\_\_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_, including but not limited to, all x-rays, medical reports, progress reports, reports of diagnostic tests, medical opinions and /or any other knowledge or information which you may possess, and for doing so let this be your good and sufficient authority.

Dated at the City of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, in the Province of \_\_\_\_\_\_\_\_,
this \_\_\_\_\_\_\_\_day of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, 20\_\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Patient’s Signature

This document’s primary use is to provide Kinesiologist (Kins) an example of Consent Form to be used within his/her practice. CKA is not responsible for consequences and damages that may occur as an outcome of its use and adaptation by Kinesiologists. It is to be stressed that the aim is to guide Kins and if Kins are in difficulty over interpretation they should seek independent legal advice.