ADVANCED COGNITIVE COMMUNICATION REHAB

Authorization Form

Client Name: _____

Address: _____

Address 2: _____

City: _____ Prov: _____ Postal Code: _____

I, _ , hereby authorize Rachel Dubé of Advanced Cognitive Communication Rehab, to obtain, review, release and copy medical records pertaining to myself. I also authorize the representative of named clinic to communicate with the following list of individuals about my medical status and therapeutic programming and progress.

1. _____

2. _____

3. _____

4. _____

Client's Signature: _____ Date: (MM/DD/YYYY): _____

Print Name: _____