ADVANCED COGNITIVE COMMUNICATION REHAB

Authorization Form

Client Name: _____

Address: _____

Address 2: _____

City: _____ Prov: _____ Postal Code: _____

Claim Number: _____ Policy Number:_____

Date of Loss: _____

Date of Birth (MM/DD/YYYY): _____

I, _ , hereby authorize, permit and allow Rachel Dubé of Advanced Cognitive Communication Rehab, to obtain, review, release and copy all medical and employment records pertaining to myself. I also authorize the representative of named clinic to release copies of my medical and employment records to the following list of individuals on a need to know basis pertaining to injuries sustained in the above dated accident.

1. _____

2. _____

3. _____

4. _____

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

Print Name: _____