

Consent to Share Information

Client Name:

Paul Sparrow

DOB:

31-3-1972

Date:

8-11-24.



As part of our commitment to providing you with the highest quality of care, we aim to foster effective communication between your chiropractic and massage therapy treatments.

To enhance your treatment plan and ensure coordinated care, I am requesting your permission to share relevant information about your health and treatment progress with the chiropractic team at Riverview Chiropractic. This collaboration will allow us to tailor our approaches to your specific needs and optimize your overall well-being.

Please be assured that any information shared will be handled with the utmost confidentiality and in accordance with all privacy regulations.

If you consent to this information sharing, please sign below:

I, Paul Sparrow, hereby give permission for my remedial massage therapist and the chiropractic team at Riverview Chiropractic to exchange relevant health information concerning my treatment.

Client Signature:

Date:

8-11-24.