Consent to Share Medical Information

Patient information

First name: _____ Last name: _____

Address: _____ City: _____

Postal Code: _____ Phone number: _____

D.O.B _____

Month/Day/Year

Shared between Vicki Froemchen from Vicki's Aquatic Therapy and:

Name of person or clinic: _____

Address: _____ City: _____

Phone number: _____

Date: _____ Signature: _____

Month/Day/Year