KLEINBURG
INTEGRATIVE HEALTH

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AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO NATUROPATHIC DOCTOR

Fax: 1.833.523.2466

(Please fax this form back with the patients records)

To: Dr.: _____ (please print)
Fax No#: _____
Address: _____
_____
Telephone: _____

From: Patient: _____ (please print)
Date of Birth: _____
Address: _____
_____
Telephone: _____

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

X-Rays _____

Blood Test Results _____

Other _____

On my behalf, I _____ **give my permission to receive/send**

the above listed reports to Dr. _____, ND. I release from you all legal

responsibility or liability that may arise from this authorization.

Signature of patient: _____

Date: _____

Naturopathic Doctor (please print) _____ Lic #_____

Signature of ND_____