KLEINBURG
INTEGRATIVE HEALTH

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_____

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