Doctors PRACTICE Naturae DISPENSARY

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AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO DOCTORS NATURAE

(Please send a copy of this form back with records)

Fax: (905) 336 – 9622

SECTION 1:

(Patient to complete Section 1 and 3 of this form)

Practitioner: _________________________________ **Patient:** _________________________________

Fax #: _________________________________ **Date of Birth:** _________________________________

City: _________________________________ **Address:** _________________________________

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Practitioner: _________________________________

Fax #: _________________________________ **Tel #:** _________________________________

City: _________________________________

SECTION 2:

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _________________________________

Laboratory Results __________ Most recent bloodwork __________

Imaging Results _________________________________

Other _________________________________

SECTION 3:

I ________________________ give permission for Doctors Naturae to receive/send the above listed reports on my and or my child's behalf. I understand that this is a cooperative effort by the practitioners involved to share information that will lead to a better understanding of my health care needs and will facilitate more comprehensive patient care.

I release from you all legal responsibility or liability that may arise from this authorization.

SIGNATURE OF PATIENT/GUARDIAN: ______________________________ **DATE:** ______________

SIGNATURE OF REQUESTING PRACTITIONER: _________________________ **DATE:** ______________

Doctors Nature

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