Whitney Young ND and Kerri Fullerton ND

93 Bell Farm, Rd. Barrie, ON L4M 5G1
705-792-6717 fax 866-735-8688

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

(Please fax this form back with the records)

To: Dr. _____
Fax No#: _____
Address: _____
_____
_____
Telephone: _____

From: Patient: _____
Date of Birth: _____
Address: _____
_____
_____
Telephone: _____

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records: _____

X-rays: _____

Laboratory Results: _____

Other: _____

On behalf of Whitney Young ND or Kerri Fullerton ND, I _____ give permission to receive/send the above listed reports on my behalf. I release from you all legal responsibility or liability that may arise from this authorization.

Signature of patient: _____
Date: _____
Witness: _____

Whitney Young, ND #1636/Kerri Fullerton, ND #1236