

Whitney Young ND, Becky Lee ND, Sarah Kiss ND  
Katie Rothwell ND, Morgan Ramsay ND

93 Bell Farm, Rd. Unit# 103 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, Becky Lee ND, Katie Rothwell ND, Sarah Kiss ND,  
Morgan Ramsay 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: \_\_\_\_\_

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Whitney Young, ND #1636, Becky Lee ND #1833, Katie Rothwell, ND # 2983  
Sarah Kiss ND #3600, Morgan Ramsay ND #3905