Miranda Naturopathic Clinic

AUTHORIZATION FOR RELEASE OF RECORDS

Please fill out the following form and fax it to your Medical Doctor's office. Your Medical Doctor's office need your authorization to fax our clinic a copy of the results of blood work or any other testing that you may have done.

Patient's Full Name: _____ Date of Birth: _____

Address: _____

Telephone (home): _____ (office):_____

Medical Doctor: _____ Fax #:_____

Address: _____ Phone:_____

I AUTHORIZE YOU TO FURNISH A COPY OF:

Document	Check	Details
Health Records		
Laboratory Results		
X-Rays		
Other		

To: ***Miranda Naturopathic Clinic***, 467 Westney Rd. S, Unit #10, Ajax, ON , L1S 6V8
C/O: Sandra Miranda BSc, ND. (License #972). ***TEL# (905)239-3900***
FAX# (905)239-3904
I release from you all legal responsibility of liability that may arise from this authorization.

Signed: _____ Date: _____