Request for Release of Medical Records

Date: _____

To: _____

I, _____ hereby authorize and request the release of:

- Any and all medical records.
- Any and all lab work.
- Only the following records: _____

_____

Birth Date: _____ SIN#: _____

Alberta Health Care Number: _____

Be released to:

Dr. Alexa Birdgeneau ND
Centre for Natural Medicine Inc.
1025 1st Ave NE
Calgary, AB, T2E 9C6
403.542.3763 phone
1-888-315-4231 fax

I acknowledge that a reasonable fee may be incurred for the copying and mailing of my personal medical record. Please forward the invoice directly to me at the following address:

_____

_____

I understand that my records may contain information regarding the diagnosis or treatment of HIV (AIDS virus), other sexually transmitted diseases, drug and/ or alcohol abuse, mental illness or psychiatric treatment. I give my specific authorization for these records to be released:

Signature: _____

Printed Name: _____

Witness: _____

_____ If checked please send any X - Rays on this patient. Thank you.