



# BIHC

Belleville Integrative  
Health Centre

## CONSENT TO RELEASE HEALTH RECORDS

DATE OF REQUEST: \_\_\_\_\_

DOCTORS NAME: \_\_\_\_\_

PATIENTS NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

REPORTS TO BE RELEASED: \_\_\_\_\_

RELEASE TO: \_\_\_\_\_

### Type of Delivery:

Patient

Pick- Up

Mail

Purolator

Fax

\_\_\_\_\_

\_\_\_\_\_

Patient Signature

Date

\_\_\_\_\_

Signature of Witness

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ACTIVE RELEASE TECHNIQUES    MEDICAL ACUPUNCTURE    REHABILITATION & CONDITIONING