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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