Request for Release of Medical Information

HAWTHORNE NATUROPATHIC CENTRE LTD.
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PH (250) 598-3314 FAX (250) 598-3317

DATED: ______________________
TO: ______________________
NAME: ______________________
DOB: ______________________

The above named patient is attending this office for naturopathic medical advice and supportive care. They have given us your name as having records of their medical history and recent diagnostic assessments. We would appreciate a copy of the following.

Summary of findings: ___________________________________

Diagnostic Imaging Reports: ___________________________________

Cardiac Pulmonary Function Studies: ___________________________________

Blood Tests: ___________________________________

Pathology Reports: ___________________________________

Other: ___________________________________

Thank you for your cooperation.

Sincerely,

Dr. R. Lovink, ND

PERMISSION GRANTED BY PATIENT: _________________________