Request for Release of Medical Information

HAWTHORNE NATUROPATHIC CENTRE LTD.
1726 RICHMOND AVENUE
VICTORIA, BC V8R 4P8
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. S. Chapell ND

PERMISSION GRANTED BY PATIENT: _____