

**AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE
PROFESSIONAL TO Kilborn Naturopathic & Wellness Centre**

Kilborn Naturopathic & Wellness Centre
Phone: 613-738-8000 Fax: 613-738-3899
201-1385 Bank Street Ottawa, ON K1H 8N4

(Please fax this form back with the records)

To: Dr.: _____
(please print)

From: Patient: _____
(please print)

Fax No#: _____

Date of Birth: _____

Address: _____

Address: _____

Telephone: _____

Telephone: _____

PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED AUTHORIZATION FORM

Health Records _____

X-Rays _____

Laboratory Results _____

Other _____

On behalf of Vivienne Guy N.D., I _____ give
permission to receive/send the above listed reports on my behalf. I release from you all legal
responsibility or liability that may arise from this authorization. (If patient is under the age of 18 signature of Legal
Guardian or Parent is required)

Signature of patient: _____
Date: _____
Witness: _____

Naturopathic Doctor (please print) Vivienne Guy Lic # 1401