Dr. Deirdre A.W. Jasper BSc, ND (#074)
#5-414 Westmount Drive, Winnipeg, MB R2J 1P2
T: (204) 256-2273 F: (204) 257-2449 W: www.winnipegnaturopathicdoctor.ca

For your first Bowen or Acupuncture (16+) patient consultation:

As requested, please find attached naturopathic intake materials and additional information. Please fill out and return all completed forms, including informed consent, to Dr. Jasper PRIOR to your first appointment.

I am also attaching the ***"Authorization for Release of Medical Information"*** form -- this form is optional to you and may be filled out and sent back to me ASAP, at which time I can forward to your doctor(s). The purpose of this form is to release recent test results from your doctor(s) to your naturopathic file -- I use this information to help reach a diagnosis, and in order to better understand your health concerns. This is only done if I have your consent, and is not mandatory, but strongly encouraged.

If you have any other pertinent health information on hand please feel free to forward along as well.

The initial Acupuncture or Bowen consultation and treatment can run up to 90-min. During the initial consultation your intake forms will be reviews, an examination may follow and an initial treatment will be given as time allows. Subsequent treatments are typically booked for 60-min (or as recommended by Dr. Jasper.)

Payment is requested at the conclusion of the visit (we take cash, cheque, debit, e-transfer, Visa and Mastercard), and you may wish to keep the receipt to forward to your extended benefits health insurance company for reimbursement of naturopathic services.

Please read and sign the "***Consent and Waiver of Liability: Electronic Communication***" form if you wish to communicate about your health care by email with Dr. Jasper.

Thanks for your interest in naturopathic medicine and I look forward to meeting with you!

--Dr. Jasper

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Adult Patient In-take Form Date filled out:

Surname: ______________________ Given Names: ______________________

Birth date (dd/mm/yyyy): ______________ Complete Address: ______________________

____ E-mail: ______________________

Home phone no.: ______________________ Other phone no.: ______________________

Phone # to leave messages at?: ____________ Occupation(s): ______________________

Marital status: ___________ Children/ dependents: ______________________

Emergency Contact (Name & Phone): ______________________________________

How did you hear about us? ______________________________________

Have you seen an ND before? (who, when?) ______________________________

Current health care providers (*please list name & occupation*):

______________________ ______________________ ______________________

Main Health Concerns/ Diagnoses (date of diagnosis):

____

____

____

Treatment goals:

____

Current Medications & Supplements (brand, dose, how long taken): ______________________

____

____

____

____

Allergies/ Sensitivities? (*Foods, animals, environmental, etc.*) ______________________________

____

____

Do you smoke tobacco? Have you ever? (When? How much per day? For how long?)

Typical diet: Diet restrictions (e.g. vegetarian, vegan, food allergies)? ____________________

Breakfast ____________________

Lunch ____________________

Dinner ____________________

Snacks ____________________

Beverages ____________________

Do you consume any of the following (*How much daily? Weekly?*):

Soda pop		Coffee/Tea		Marijuana	
Candy		Alcohol		Recreational drugs	

Past Medical History (conditions, illness, injury): ____________________

____

____

Hospitalizations/ surgery: ____________________

____

____

FAMILY HISTORY (***please state family member, i.e. mother, grandfather***, *etc.*):

Allergies		Arthritis	
Digestive problems		Osteoporosis	
Diabetes		Anxiety/ Depression	
High blood pressure		Cancer (what type?)	
Heart attack		Thyroid (low/ high)	
Stroke		Gynecological problems	
High cholesterol		OTHER?	

How do you handle your stress?

____

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Review of Systems – Please circle the best response & elaborate

Y A condition you have NOW and are currently suffering from
P A condition you had in the PAST or intermittently
N A condition you have NEVER had or almost never have

				Comments:
GENERAL				
Current age, weight (lbs.), height (in.)				
Are you /might you be pregnant?				
Fatigue (time of day? since when?)	**Y**	**P**	**N**	
SKIN				
Rash / Hives (circle one)	**Y**	**P**	**N**	
Eczema	**Y**	**P**	**N**	
Psoriasis	**Y**	**P**	**N**	
Acne / Boils (circle)	**Y**	**P**	**N**	
Itching (where?)	**Y**	**P**	**N**	
Lumps (where?)	**Y**	**P**	**N**	
Dryness	**Y**	**P**	**N**	
Night sweats	**Y**	**P**	**N**	
Fingernail changes (what kind?)	**Y**	**P**	**N**	
Changes in moles	**Y**	**P**	**N**	
Skin cancer	**Y**	**P**	**N**	
Hair loss/ Hair thinning (circle)	**Y**	**P**	**N**	
Dandruff	**Y**	**P**	**N**	
Fungal infections	**Y**	**P**	**N**	
Warts	**Y**	**P**	**N**	
HEAD				
Headache	**Y**	**P**	**N**	
Head injury (concussion)	**Y**	**P**	**N**	
Dizziness / Vertigo (circle)	**Y**	**P**	**N**	
EYES				
Impaired vision	**Y**	**P**	**N**	
Glasses / Contacts	**Y**	**P**	**N**	
Eye pain	**Y**	**P**	**N**	
Tearing / Dryness (circle one)	**Y**	**P**	**N**	
Double vision / Floaters (circle one)	**Y**	**P**	**N**	
Glaucoma	**Y**	**P**	**N**	
Cataracts	**Y**	**P**	**N**	
Blurring	**Y**	**P**	**N**	
Bothered by sun	**Y**	**P**	**N**	
Itching	**Y**	**P**	**N**	
Redness	**Y**	**P**	**N**	
Discharge	**Y**	**P**	**N**	

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EARS				
Impaired hearing (Hearing aid?)	**Y**	**P**	**N**	
Ear pain	**Y**	**P**	**N**	
Tinnitus (ringing in ears)	**Y**	**P**	**N**	
Itching	**Y**	**P**	**N**	
Discharge (Colour? Odour?)	**Y**	**P**	**N**	
Ear Infections	**Y**	**P**	**N**	
NOSE and SINUSES				
Stuffiness	**Y**	**P**	**N**	
Sinus pain	**Y**	**P**	**N**	
Runny nose (Colour?)	**Y**	**P**	**N**	
Post-nasal drip	**Y**	**P**	**N**	
Number of colds per year?				
Nose bleeds	**Y**	**P**	**N**	
MOUTH and THROAT				
Frequent sore throats (>3 per year?)	**Y**	**P**	**N**	
Tonsils/ Adenoids removed (circle)	**Y**	**P**	**N**	
Sore tongue/ mouth	**Y**	**P**	**N**	
Gum problems	**Y**	**P**	**N**	
Hoarseness	**Y**	**P**	**N**	
Mononucleosis (When diagnosed?)	**Y**	**P**	**N**	
Dental cavities (How many silver?)	**Y**	**P**	**N**	
Mercury fillings removed (When? #?)	**Y**	**P**	**N**	
Dentures/ partial (top / bottom)	**Y**	**P**	**N**	
Dental surgeries (what sort, when?)	**Y**	**P**	**N**	
Teeth grinding? (Night guard?)	**Y**	**P**	**N**	
Loss of taste	**Y**	**P**	**N**	
NECK				
Lumps	**Y**	**P**	**N**	
Swollen glands	**Y**	**P**	**N**	
Goitre (Enlarged thyroid gland)	**Y**	**P**	**N**	
Pain/ stiffness	**Y**	**P**	**N**	
RESPIRATORY				
Cough	**Y**	**P**	**N**	
Sputum / mucus	**Y**	**P**	**N**	
Spitting up blood	**Y**	**P**	**N**	
Wheezing	**Y**	**P**	**N**	
Asthma	**Y**	**P**	**N**	
Bronchitis	**Y**	**P**	**N**	
Pneumonia	**Y**	**P**	**N**	
Pleurisy (Inflammation of lung lining)	**Y**	**P**	**N**	
Emphysema	**Y**	**P**	**N**	
Difficulty breathing	**Y**	**P**	**N**	
Pain on breathing	**Y**	**P**	**N**	
Shortness of breath	**Y**	**P**	**N**	

Shortness of breath at night	**Y**	**P**	**N**	
Shortness of breath on lying down	**Y**	**P**	**N**	
Tuberculosis	**Y**	**P**	**N**	
Tuberculin Test (Test Result?)	**Y**	**P**	**N**	
Last chest x-ray (Date? Results?)	**Y**	**P**	**N**	
CARDIOVASCULAR				
Heart disease	**Y**	**P**	**N**	
High / Low blood pressure (circle)	**Y**	**P**	**N**	
Heart murmurs	**Y**	**P**	**N**	
Rheumatic fever	**Y**	**P**	**N**	
Chest pain	**Y**	**P**	**N**	
Swelling in ankles	**Y**	**P**	**N**	
Palpitations, fluttering	**Y**	**P**	**N**	
Heart tests (Type? Date? Results?)	**Y**	**P**	**N**	
BREASTS				
Lumps	**Y**	**P**	**N**	
Pain/ tenderness (When?)	**Y**	**P**	**N**	
Nipple discharge	**Y**	**P**	**N**	
Breastfeeding	**Y**	**P**	**N**	
GASTROINTESTINAL				
Difficulty swallowing	**Y**	**P**	**N**	
Heartburn/ Indigestion (circle one)	**Y**	**P**	**N**	
Change in thirst (Decreased? Increased?)	**Y**	**P**	**N**	
Change in appetite (Decreased? Increased?)	**Y**	**P**	**N**	
Any foods you CRAVE? (bread, sugar…)				
Nausea	**Y**	**P**	**N**	
Vomiting	**Y**	**P**	**N**	
Bowel movements (Per day or per week?)	**Y**	**P**	**N**	
Is this a recent change?				
Blood in stool	**Y**	**P**	**N**	
Frequent belching	**Y**	**P**	**N**	
Frequent passing gas	**Y**	**P**	**N**	
Jaundice (Yellow skin)	**Y**	**P**	**N**	
Liver disease (fatty liver, hepatitis)	**Y**	**P**	**N**	
Gallbladder disease (gallstones)	**Y**	**P**	**N**	
Ulcer	**Y**	**P**	**N**	
Crohn's or Ulcerative Colitis (circle)	**Y**	**P**	**N**	
Irritable Bowel Syndrome (IBS)	**Y**	**P**	**N**	
Food poisoning (when?)	**Y**	**P**	**N**	
Parasites / Pinworms (when?)	**Y**	**P**	**N**	
Diarrhea	**Y**	**P**	**N**	
Rectal bleeding	**Y**	**P**	**N**	
Hemorrhoids	**Y**	**P**	**N**	
Black, tarry stool	**Y**	**P**	**N**	
Abdominal pain	**Y**	**P**	**N**	
Hernia (Where?)	**Y**	**P**	**N**	

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URINARY				
Pain on urination	**Y**	**P**	**N**	
Frequent urination (day / night?)	**Y**	**P**	**N**	
Urination at night	**Y**	**P**	**N**	
Inability to hold urine	**Y**	**P**	**N**	
Frequent urinary tract infections	**Y**	**P**	**N**	
Kidney stones	**Y**	**P**	**N**	
Blood in urine	**Y**	**P**	**N**	
Hesitancy (Incomplete urination)	**Y**	**P**	**N**	
MALE REPRODUCTIVE				
Testicular masses/ lumps	**Y**	**P**	**N**	
Testicular pain	**Y**	**P**	**N**	
Are you sexually active?	**Y**	**P**	**N**	
Erectile dysfunction	**Y**	**P**	**N**	
Prostate enlargement/ infection/ cancer	**Y**	**P**	**N**	
Sexually transmitted disease(s)	**Y**	**P**	**N**	
Penis discharge/ sores	**Y**	**P**	**N**	
FEMALE REPRODUCTIVE				
Age of first period				
Days of bleeding in cycle (How long do you bleed?)				
Length of cycle (e.g. 28-days, 30-days…)				
Bleeding between periods	**Y**	**P**	**N**	
Irregular cycles	**Y**	**P**	**N**	
Painful menses	**Y**	**P**	**N**	
Excessive bleeding	**Y**	**P**	**N**	
Clotting (small, med., lg.)	**Y**	**P**	**N**	
PMS (What kind?)	**Y**	**P**	**N**	
Pain during intercourse	**Y**	**P**	**N**	
Low libido / Sexual difficulties	**Y**	**P**	**N**	
Sexually transmitted disease (describe)	**Y**	**P**	**N**	
Birth control?	**Y**	**P**	**N**	
What type, how long?				
Number of pregnancies				
Number of miscarriages				
Uterine or ovarian diagnosis? (fibroids, enometriosis, cysts…)				
Difficulty conceiving	**Y**	**P**	**N**	
Last menstrual period?				
Vaginal pain	**Y**	**P**	**N**	
Vaginal itching	**Y**	**P**	**N**	
Vaginal discharge	**Y**	**P**	**N**	
Yeast infections (How many?)	**Y**	**P**	**N**	
Last PAP & pelvic (Date, Abnormal findings?)				

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MUSCULOSKELETAL				
Joint pain (where?)	**Y**	**P**	**N**	
Joint stiffness (where?)	**Y**	**P**	**N**	
Arthritis (osteo- or rheumatoid?)	**Y**	**P**	**N**	
Broken bones	**Y**	**P**	**N**	
Muscle cramps/ spasms	**Y**	**P**	**N**	
Muscle weakness	**Y**	**P**	**N**	
Joint swelling	**Y**	**P**	**N**	
Backache	**Y**	**P**	**N**	
PERIPHERAL VASCULAR				
Deep leg pain	**Y**	**P**	**N**	
Cold hands and/or feet	**Y**	**P**	**N**	
Varicose veins / spider veins (circle)	**Y**	**P**	**N**	
Hand and/or feet swelling	**Y**	**P**	**N**	
Leg/ foot ulcers	**Y**	**P**	**N**	
NEUROLOGIC				
Fainting	**Y**	**P**	**N**	
Seizures/ convulsions	**Y**	**P**	**N**	
Paralysis	**Y**	**P**	**N**	
Numbness/ tingling (where?)	**Y**	**P**	**N**	
Loss of memory	**Y**	**P**	**N**	
Involuntary movements/ twitching	**Y**	**P**	**N**	
Loss of balance	**Y**	**P**	**N**	
Speech problems	**Y**	**P**	**N**	
ENDOCRINE				
Heat intolerance	**Y**	**P**	**N**	
Cold intolerance	**Y**	**P**	**N**	
Known thyroid trouble? (Hyper/hypo?)	**Y**	**P**	**N**	
Excessive thirst	**Y**	**P**	**N**	
Excessive hunger	**Y**	**P**	**N**	
Excessive sweating	**Y**	**P**	**N**	
Diabetes (Type 1 or Type 2?)	**Y**	**P**	**N**	
Low blood sugar (hypoglycemia)	**Y**	**P**	**N**	
Hormone replacement therapy	**Y**	**P**	**N**	
BLOOD				
Anemia (Low iron in blood)	**Y**	**P**	**N**	
Low vitamin B_{12}	**Y**	**P**	**N**	
High cholesterol (last checked?)	**Y**	**P**	**N**	
Excessive bruising when injured	**Y**	**P**	**N**	
Excessive bleeding when cut	**Y**	**P**	**N**	
Blood transfusion	**Y**	**P**	**N**	

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MEDICATION HISTORY
Have you taken antibiotics for acne for 1 month or longer?
Have you, at any time in your life, taken other "broad-spectrum" antibiotics for respiratory, urinary, or other infections for 2 months or longer, or in short courses four or more times in a 1 year period?
About how many times have you taken an antibiotic in your lifetime?
Have you taken prednisone or other cortisone-type drugs? (how long?)
Have you taken heartburn medication? (how long?)
Do you take aspirin, ibuprofen, naproxen or other NSAID medications? (how often?)
ALLERGIC HISTORY
Reaction to vaccine in the past? (Which ones?)
Have you found black mould in your house? (when?)
Are you sensitive to scents, smoke or other airborne chemicals? (describe)
Allergies (List)

EMOTIONAL and LIFESTYLE				
Depression	**Y**	**P**	**N**	
Seasonal Affective Disorder	**Y**	**P**	**N**	
Mood swings	**Y**	**P**	**N**	
Anxiety or Nervousness	**Y**	**P**	**N**	
Phobias (Please list)	**Y**	**P**	**N**	
Addictions (Please list)	**Y**	**P**	**N**	
Emotional traumas? (When?)	**Y**	**P**	**N**	
Sleep problems (Insomnia, waking)	**Y**	**P**	**N**	
Do you awake rested?	**Y**		**N**	
Hours of sleep per night? (Weekday)	**Y**		**N**	
Do you watch TV? (Hours per day)	**Y**		**N**	
Do you exercise? (What type, how often)	**Y**		**N**	
Do you have pets/ animals (Type?)	**Y**		**N**	
Have you ever been treated for drug dependence? (when?)	**Y**	**P**	**N**	

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Informed Consent to Naturopathic Treatment

Naturopathic Doctors are trained to evaluate their patients through interview, physical exams and through various diagnostic tests. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

Naturopathic Doctors are regulated by the Board of Directors, of the Manitoba Naturopathic Association, and under strict adherence to the Naturopathic Act. Every Naturopathic Doctor must maintain license through their Association in order to legally practice.

Practitioners of Naturopathic Medicine may employ natural medicines and techniques such as nutritional counselling and nutritional supplements, botanical medicines, Asian medicines & acupuncture, homeopathic remedies, physical medicine (such as Bowen therapy), and lifestyle counselling.

Please check the following therapies listed below that you DO NOT wish to participate in, unless later indicated:

- ❑ ***Clinical nutrition*** is counselling on the use of special diets and nutritional supplements to address nutritional deficiencies, treat disease processes, and promote health.

- ❑ ***Botanical medicine*** is a plant-based medicine that involves the use of herbs to assist in recovery from injury and disease and to promote general well-being. Herbs may be consumed or applied topically. Some examples include consuming herbs as teas, tinctures, tablets, capsules, creams, compresses, or suppositories.

- ❑ ***Homeopathy*** is a form of medicine using highly dilute quantities of naturally occurring plants, animals, minerals and other substances to stimulate the body's healing response. Homeopathy is effective at addressing the whole person, both on a physical and mental/emotional level.

- ❑ ***Acupuncture*** refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Moxabustion and cupping are additional Eastern soft tissue techniques that can be employed.

- ❑ ***Physical medicine*** refers to the use of hands-on techniques such as soft tissue manipulation (massage, acupressure), and the use of hot or cold applications to specific areas on the body to stimulate circulation (i.e. hydrotherapy).

- ❑ ***The Bowen Technique*** is a hands-on technique that involves the gentle manipulation of soft tissues at specific points on the body for the purposes of treating musculoskeletal, neurological and systemic conditions of the individual.

- ❑ ***Lifestyle counselling*** involves discussing and reforming daily habits (such as sleep hygiene, exercise regimes, and relaxation techniques), as well as removing risk factors to one's health.

During your initial consultation your Naturopathic Doctor will guide you through a case-taking interview, may perform a physical examination, request a urine sample, and/or recommend any necessary laboratory analyses. You may be referred to an external laboratory or health care practitioner for certain diagnostic testing (e.g. blood tests, saliva testing, imaging studies, etc.)

When necessary, it is the responsibility of the Naturopathic Doctor to refer to other healthcare practitioners for confirmation of diagnosis of an illness, disease, or any physical or mental disorder. Naturopathic Doctors are not trained to dispense prescription medications, perform surgery, or provide psychiatric counselling services.

Even the gentlest therapies may cause complications in certain physiological conditions (e.g. pregnancy, lactation, very young children, or those taking multiple prescription medications). Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease. It is very important that you inform your doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your Naturopathic Doctor immediately.

I recognize the potential risks and benefits of these procedures as described below:

Potential risks *(not an exhaustive list)*: aggravation of pre-existing symptoms, allergic reactions to prescribed herbs and supplements, side effects of natural medicines, inconvenience of lifestyle changes, injury from injections or procedures, fainting or puncturing of an organ with acupuncture needles, or muscular/soft tissue pain from hands-on treatments.

Potential benefits (not an exhaustive list): restoration of health and the body's maximum functional capacity without the use of drugs or surgery, relief of pain and symptoms of illness and disease, assistance in injury and disease recovery, and the prevention of disease and its progression.

Naturopathic Physicians are in no way accountable for the outcome of treatment(s) given in adherence to the Naturopathic Act; they in no way guarantee a "cure" of any illness or disease. Naturopathic Doctors shall provide empathetic, professional, and unbiased care for all patients that request treatment. The Naturopathic Doctor and the patient reserve the right to terminate Naturopathic care/ treatment at any time, as they deem necessary.

I understand that a record will be kept of the health services provided to me. As a patient, I shall provide my Naturopathic Doctor with updated information pertaining to my health to the best of my ability. Information will be gathered solely for the purposes of treatment, and will be kept confidential and shall not be released to other parties without my consent, unless required by law. I understand that I may request any portion of my medical record by paying the appropriate fee.

I understand that all charges are to be paid at the time of the visit unless specific arrangements have been made prior to my scheduled appointment. I understand that a fee may be charged for any missed appointments or late cancellations (less than 24 hours).

With this knowledge, I voluntarily consent to Naturopathic treatments offered or recommended to me by my Naturopathic Doctor, unless omitted as indicated above. I realize my Naturopathic Doctor has made no guarantees regarding cure or improvement of my condition, nor do I expect the Doctor to anticipate and explain all potential risks and complications. I intend this consent to apply to all my present and future Naturopathic care, unless a new agreement has been reached and a new consent form has been signed.

Dated this _____________day of ________________, 20______.

______________________________	____________________________________
Patient's Signature	Guardian's Signature (under 18 years)
______________________________	____________________________________
Patient's Name (please print)	Guardian's Name (please print)

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Consent and Waiver of Liability: Electronic Communication

Electronic communication is a widely accepted form of communication. While it cannot replace personal encounters between you and your health care provider, it can be a convenient way to exchange information. All electronic communication will be acknowledged in a timely fashion. However, we do not monitor emails when the office is closed for weekends, evenings, statutory holidays and vacations. Please consider our office hours when you are waiting for a reply to your electronic communication. As a general rule, we will respond to patient emails within 3 business days. If you do not receive a response within the designated time period, please assume that your email was not received and call the office to follow up.

I understand and agree that:

- Electronic communication is not an appropriate substitute for clinical examinations. I am responsible for following up on Dr. Deirdre Jasper N.D.'s (Dr. Jasper) electronic communication and for scheduling appointments where warranted;
- Electronic communication is not to be used in emergencies, or when I need information or advice urgently. In case of an emergency, go to your nearest urgent care facility or call 911;
- Electronic communication will not be used for any purpose outside the context of my direct patient-health care provider relationship;
- Electronic communication between me and Dr. Jasper will become part of my confidential patient record;
- This medical practice may use electronic communication to send me health promotion material and other educational resources;
- Electronic communication is a privilege that may be withdrawn at the discretion of Dr. Jasper;
- Electronic communication between Dr. Jasper is only for the residents of Manitoba and is governed by the laws of the Province of Manitoba;
- Electronic communication is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the electronic communication once it has been sent;
- Electronic communication can introduce viruses into a computer system and potentially damage or disrupt the computer;
- Electronic communication can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the physician or patient. Electronic communication senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients. Electronic communication is indelible. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or cyberspace;
- Use of electronic communication to discuss sensitive information can increase the risk of such information being disclosed to third parties;
- Emails may be forwarded or referred, as necessary, for diagnosis, treatment, or health care operations, with the permission of the patient;
- Dr. Deirdre Jasper N.D. is not responsible for information loss due to technical failures;
- I will notify the Dr. Jasper of any changes to my electronic communication address;
- I acknowledge Dr. Jasper's right to, upon provision of written or electronic communication notice, withdraw the option of communicating through email;

Dr. Deirdre A.W. Jasper BSc, ND (#074)
#5-414 Westmount Drive, Winnipeg, MB R2J 1P2
T: (204) 256-2273 F: (204) 257-2449 W: www.winnipegnaturopathicdoctor.ca

I hereby authorize Dr. Deirdre Jasper, N.D. to disclose my personal health information to me via the following:

Email address (print clearly): ____

Mobile number to be used for texting (if applicable): ____

I have read and understood the "**Consent and Waiver of Liability: Electronic Communication"** form and fully acknowledge that sending personal health information via electronic communication is not secure and I fully accept the risks and responsibility involved with this. I hereby waive any and all claims against Dr. Deirdre Jasper N.D. in connection with the disclosure of my personal health information via email.

Name of Patient (print): ____

Signature of patient (or guardian/ legal representative): ______________________________ Date: ___________

Relationship to patient (if signed by guardian/ representative): ____

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PLEASE NOTE THAT THIS DOCUMENT DOES NOT INDICATE A TRANSFER OF PATIENT CARE!

Authorization for Release of Medical Information

Patient's Name: ____ Date of Birth: ____________

Address: ____ City: ______________________

Prov/ State: _______________ Postal Code/ Zip: _________________

MH Reg/ Health ID #: __________________________ PHIN #:

(Practitioner's info here:)

❑ I authorize Dr. Jasper to ***OBTAIN*** information from:

____
Name of Provider or Facility

____
Address

____
City, Prov/ State, Postal Code/ Zip

____
HCP's Fax # (include area code) Tel #

TYPE OF RECORDS REQUESTED:

____
____

Signature of Patient or Representative: ____________________________________

Relationship of Representative to Patient: _________________________________

Date: _______________________

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