Dr. Deirdre A.W. Jasper, BSc, ND
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Authorization for Release of Medical Information

Patient's Name: _____ Date of Birth: _____
Address: _____ City: _____
Prov/ State: _____ Postal Code/ Zip: _____
MH Reg/ Health ID #: _____ **PHIN #:** _____

Date of Request: _____

(Practitioner's info here:)

❑ ***I authorize Dr. Jasper to SHARE information with***:

_____
Name

_____
Address

_____
City, Prov/ State, Postal Code/ Zip

_____
Tel # Fax#

TYPE OF INFORMATION WILLING TO SHARE:

_____
_____

RESTRICTIONS TO SHARED INFORMATION: (what you don't wish to share)

_____
_____

Signature of Patient or Representative: _____

Relationship of Representative to Patient: _____

Date: _____