Dr. Deirdre A.W. Jasper, BSc, ND
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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 #:** _____

Date of Request: _____ **Date Needed**: ASAP

(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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