AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE PROFESSIONAL TO Rabia Meghji BSc. ND
Docere Wellness Centre Fax#1877 811 1373

(Please fax this form back with the records)

To: Dr.: _____ **From: Patient:**_____
(please print) (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 _____

I,_____, give Rabia Meghji N.D. 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.

Signature of patient: _____

Date: _____

Witness: _____

Naturopathic Doctor **Dr. Rabia K Meghji ND** Lic #**1611**

Save Form