true potential
health services inc.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Doctor's Name: _____
Clinic: _____
Tel #:_____
Fax #:_____

Patient's Name: _____
Patient's Birthday: _____
PHN: _____

I request and authorize the release of the following Medical Records to:

Dr. Jacqui Fleury	Dr. Michelle Marcoux
Dr. Naomi Whelan	Dr. Kahlen Pihowich

Health Records_____

X-Rays_____

Lab Result_____

Other: _____

Client's Signature: _____
Date: _____

Please fax the requested information to:

Fax: (306) 373-5207
#3, 1810 – 8th Street East
Saskatoon, SK S7H 0T6
Phone (306) 373-5209