Woodside Clinic
naturopathic medicine
136 Jenkins Rd. Oakland, ON, N0E 1R0, 519-484-9999
Dr. Elizabeth Storjohann BSc ND, RTCMP,
Dr. Farah Mirzaagha BSc, ND, RTCMP

AUTHORIZATION FOR RELEASE OF RECORDS

Patient's Full Name: _____ Date of Birth: _____
Please print clearly DD/MM/YYYY

Patient's Address:_____ Province, Postal Code:_____

Phone Number:_____ Work Number:_____

Name of Doctor: _____
Please print clearly

Doctor's Address: Doctor's Telephone:

_____ Office: _____

_____ Fax: _____

I, _____ (patient's name)

AUTHORIZE THE DOCTOR ABOVE TO FURNISH A COPY OF:

☐ Health Records _____

☐ X-Rays _____

☐ Laboratory Results _____

☐ Other _____

Please fax back to the Woodside Clinic along with this form to 519-484-9995
I release you from all legal responsibility or liability that may arise from this authorization.

Signed: _____

Date: _____

Witness: _____