

Kerri Fullerton, BSc, ND

67 Patterson, Rd. Barrie, ON L4N 3V9
705-792-6717 fax 705-792-9344

**AUTHORIZATION FOR RELEASE OF RECORDS FROM HEALTH CARE
PROFESSIONAL TO KERRI FULLERTON
(Please fax this form back with the records)**

To: Dr. _____
Fax No#: _____
Address: _____

Telephone: _____

From: Patient: _____
Date of Birth: _____
Address: _____

Telephone: _____

**PLEASE SEND THE FOLLOWING REPORTS WITH THE SIGNED
AUTHORIZATION FORM**

Health Records: _____

X-rays: _____

Laboratory Results: _____

Other: _____

On behalf of Kerri Fullerton, BSc, ND, I _____ give
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: _____

Kerri Fullerton, ND #1236