CONSENT TO RELEASE OF INFORMATION

I, _____, hereby authorize the release of my personal medical information to **Dr. Jane Reside, Naturopathic Physician**, to include lab results, other pertinent test results, chart notes, and any other material that pertains to my health concerns and health care.

Date: _____

Signature: _____

Dr. Jane Reside, B.Sc., N.D.
Naturopathic Physician

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