DR. DIANA SEMJONOV
NATUROPATHIC DOCTOR

Release of Medical Records Request

********** Please return by fax or mail as soon as possible to: **********
Dr. Diana Semjonov, Naturopathic Doctor
Phone: 647-823-7455
Fax: 613-212-8887

Please send the following reports with the signed authorization form:

□ Laboratory results (most recent)
□ Diagnostic and medical imaging
□ All medical records necessary for the continuity of care

This authorization must be written, signed and dated by the patient or by a person authorized by law to give authorization on the patient's behalf. It is valid until revoked in writing. Diana Semjonov, Naturopathic Doctor does not offer reimbursement for any charges incurred for records received.

To	From
Physician: _____	Patient Name:_____
Location (Clinic/Hospital): _____	DOB (dd/mm/yyyy): _____
Phone:_____	Address:_____
Fax:_____	_____
	_____
	Phone:_____

I, _____authorize the above named physician/clinic/hospital to release written records pertaining to the following information to Dr. Diana Semjonov, ND. The purpose of this disclosure is to assist my Naturopathic Doctor as part of my collaborative health care team in providing care to me as described in s.38 of the Personal Health Information Protection Act, 2004.

Patient signature: _____ Date (dd/mm/yy): _____

Parent/Guardian Signature:_____Date (dd/mm/yy): _____

Signature of Dr. Diana Semjonov, ND #3270: _____