



RELEASE OF HEALTH INFORMATION

Date: _____

To: _____

Fax : _____

You are hereby authorized and requested to provide to

Dr. J. Heick, Dr. R. Blackburn, and/or Dr. J. Oosterhof

the following marked information concerning: **Patient:** _____

D.O.B.: _____

- Radiographs
- Radiographic reports
- Health records
- Other _____

*Waterloo North Chiropractic and Massage
550 Parkside Dr, Unit A4
Waterloo, Ontario
N2L 5V4
Fax: 226-647-5988*

Thank you for your co-operation.

Patient's Signature



Dr. Jennifer Heick, Dr. Rebecca Blackburn & Dr. Jonathan Oosterhof
550 Parkside Drive, Unit A4, Waterloo ON N2L 5V4
519-746-3838 | wncm@rogers.com | www.wncm.ca