RELEASE OF HEALTH INFORMATION

Date: _____

To: _____

Fax : _____

You are hereby authorized and requested to provide to

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