AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I here	eby give permission	to:			
				ntz Street, Suite 202, Moncton, New and facsimile: (844) 767 -7099	
	Records of all my	hospitalization and	d/or tre	atments/investigations	
	Records of my in-patient hospitalizations for the period of: to				
	Month, Year			Month, Year	
	Records of my in-patient hospitalizations and/or treatments/investigations done as an outpatient for the period of:				
	Month, Year		_ to	Month, Year	_
	Specify any exclusion to the above:				
Full 1	Name of Patient:				
Date	of Birth:				
Phon	ne Numbers:				
Addr	ress:				
Signatures:		X			
		Witness			
Date	• •				
		dd/mm/yyyy			