RELEASE/OBTAIN OF MEDICAL INFORMATION

I, ________________________________, hereby authorize Integrative Touch Inc. to release and obtain all and any relevant information related to my personal health care file from my family doctor.
I also authorize the health care providers at Integrative Touch Inc. to exchange records and information contained in my file.

Family Doctor: ____

Address: ____
____
____

Phone: ____

In addition, I would also like Integrative Touch Inc. to release and obtain all and any relevant information related to my personal health care file from the following parties (please select):

☐ Hospital
☐ Lawyer
☐ WSIB
☐ Employer
☐ Insurance Company

________________________	________________________	________________________
Print Patient's Name	Signature (Or Parent/Guardian)	Date