AUTHORIZATION FOR USE/DISCLOSURE OF HEALTH INFORMATION

Name:____ **Date of Birth: __________________**

Last **First** **Middle**

<u>Authorization for Use/Disclosure of Information</u>: I voluntarily authorize and direct my health care provider (Please insert name of provider) ____ to use or disclose my health information during the term of this Authorization to the recipient that I have identified below.

<u>Recipient</u>: K. Shang ND, BSc (Hon)
Bayview Naturopathic Wellness
16860 Bayview Avenue,
Newmarket, ON L3Y 3W8
(905)235-5168

<u>Information to be disclosed</u>: This authorization permits the above provider to disclose the following medical records:

- ❑ All of my health information that the provider has in his or her possession, including information relating to any medical history, mental or physical condition and any treatment received by me.[1]
- ❑ All of my health information described above except for the following: ____.
- ❑ Only the following records or types of health information: (Insert dates of treatment, types of treatment or other designation.)____.

____________________________ __________________ ___________________

Signature Date Signature of Witness

[1] **NOTE: This Authorization does not extend to HIV test results, outpatient psychotherapy notes, drug or alcohol treatment records that are protected by federal law, or mental health records that are protected by the Lanterman-Petris-Short Act.**