



CONSENT FOR RELEASE OF HEALTH INFORMATION

I _____ give authorization to the release of my personal health information to Dr. Sandra Cramer BS MS DO (mp) DACNB and for her to speak with you.

Address: 4107 Upper Middle Road, Burlington, ON L7M 4G4

Phone: 905-331-9658

Fax: 905-331-5275

Dated on M/D/Y _____

Patient Signature: _____

Date of Birth: _____

Witness: _____