AUTHORIZATION TO RELEASE MEDICAL RECORDS

This form is to be completed by clients granting permission to provide a client's medical records to BetterByDesign Nutrition and/or Joy Y. Erdile MSc RD.

Patient's First Name:

Patient's LAST Name:

Date of Birth (DD/MM/YYYY):

Medical Records Requested:

The following recent lab test results:

- general blood (hematology) panel
- ferritin
- fasting blood glucose
- HbA1C
- lipid panel (cholesterol) with triglycerides
- (ALT, AST, gamma GT - if available)

Client / Patient Authorization

Client / Patient's Full Name (First Name, Middle initial, Last Name)

I, the client / patient named above hereby authorize the Physician named below to release the medical records indicated to BetterByDesign Nutrition Ltd and/or Joy Y. Erdile, MSc, RD.

Physician's Name or Medical Clinic Name (required)

Physician's Phone Number (required):

Physician's Fax Number (required):

(required) By checking off this box, I understand and agree that my typed name below is as legally binding as my physical signature.

(required) Full Name of Client / Patient - first name, initial, last name

(required) Date Signed (dd/mm/yyyy)

Personal information on this form will be used to process the disclosure(s) requested on this form and is protected from unauthorized use and disclosure in accordance with the Freedom of Information and Protection of Privacy Act and may be disclosed only as provided by that Act.

INSTRUCTIONS TO DOCTOR'S OFFICE: Please fax documents to 604-475-7475.