Records Release Form

We appreciate the forwarding of this information by fax to 403-283-0786 or email at info@resonance-wellness.com at your earliest convenience. Should you have questions, please do not hesitate to contact the front desk manager at 403-283-7683.

Records To Be Released To:

Resonance Wellness
Suite 200, 3116 4th St NW
Calgary, AB T2M 3A4
Phone: 403-283-7683
Fax: 403-283-0786
Email: info@resonance-wellness.com

Requested By: Dr. Allissa Gaul ND

Records of Patient:

Name: ______________________ DOB: ______________________

AHC#: ______________________

Records To Be Released From:

Name of Doctor/Clinic or Hospital: ______________________

Address: ______________________

Phone: ______________________

Fax: ______________________

Records Requested:

By my signature I authorize you to release confidential health information about me by the release of my medical records or a summary or narrative of my protected health information as indicated above to Resonance Wellness.
A copy of this authorization shall be as valid as the original.

____ **Complete Chart:** ______________________

____ **Chart Notes:** ______________________

____ **Lab Results:** ______________________

____ **Imaging Results:** ______________________

____ **Other:** ______________________

Date: ____________ **Please Print Name:** ______________________

Signature/Signature of Parent/Guardian: ______________________

Signature of Witness: ______________________