Authorization for Release of Medical Records

Chiropractic Sport Specialist
Dr. Dale Macdonald
BA, DC, CSCS,
FRCCSS(C), ICSSD

Chiropractic Physical and Occupational Rehabilitation Specialist
Dr. Jason Schimke
DC, FCCPOR(C)
Dr. Arif Karmali, DC, RCCSS (resident)

Naturopathic Medicine
Dr. Eric Arrata, ND

Physiotherapy
Maria Rufo, BMR-PT, CAFCI

Registered Massage Therapy
Danielle Frost, RMT
Rebecca Stoker, RM

Administrative Staff
Allyson Nason – Reception
Joy Elder - Administration

Services Offered:
Sport Chiropractic
Active Release Technique
Graston Technique

Custom Orthotics
Custom Knee Braces
Gait Analysis

Pre and Post Surgical Rehabilitation
Exercise Prescription

Medical Acupuncture
TCM Acupuncture

Platelet Rich Plasma Therapy
Prolotherapy
Biopuncture

Dietary Consultation
Food Sensitivity Testing
Salivary Hormone Testing
Urine Heavy Metal Testing

Lifestyle Counseling
Clinical Counseling
Sport Performance Counseling

Registered Massage
Sport Massage

To: Dr. _____

T: _____ F: _____

Dear Dr. _____ ,

The following patient has now come under our care. If you could please forward to us, at your earliest convenience, a COPY of the following:

- ☐ X-ray Reports
- ☐ MRI Reports
- ☐ CT Reports
- ☐ Ultrasound Reports
- ☐ Specialist Consultation Letters
- ☐ Mammogram Report
- ☐ Bone Density Results
- ☐ Histopathology Reports
- ☐ Bone Scan Reports
- ☐ Blood Work (last 2 years)

1. _____
2. _____
3. _____

I, _____ authorize release of a copy of my medical information to:

Dr. _____. I understand that this is an uninsured service and is not covered by my medical insurance. I realize there may be a fee for this service that I am responsible for. This fee is dependent upon the complexity of my request. Please fax to 403 668 4257.

Name: _____ **DOB or AHC#**: _____

Signature: _____ **Date:** _____

Accepting referrals from family physicians.