**Private Practice Name**

**Dietitian/Provider Name**

Registered Dietitian / credentials

ADDRESS

PHONE

EMAIL / FAX

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

|  |  |  |  |
| --- | --- | --- | --- |
| Patient’s Name: |  | Date of Birth: |  |
|  |  |  |  |
| I request and authorize |  YOUR PROVIDER NAME | to |
| release healthcare information of the patient named above to: |
|  | Name: |  (therapist, MD, treatment team member) |
|  | Address: |  |
|  | City: |  | State: |  | Zip Code: |  |
| This request and authorization applies to: \*check what applies\* |
| ◻ Healthcare information relating to the following treatment, condition, or dates: |  |
|  |  |
| ◻ All healthcare information |
| ◻ Other: |  |
|  |
|  |
|  |
| ◻ Yes ◻ No | I authorize the release of my medical and medical nutrition information. |
|  |
| ◻ Yes ◻ No | I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. |
| Patient or Guardian Signature: |  | Date Signed: |  |
|  |
| This authorization expires after 12 months.  |