**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. | | | | | | | | | | | | | | | | | | | |