AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name:

_____

Last First Middle

Date of Birth:_____Social Security Number (Optional):_____

I Authorize

_____

Physician Office Releasing the Information

To release the following information: Specific Dates of Service: _____

Progress/Doctors Notes Laboratory Reports
Pathology Reports Radiology/EKG Reports
Mental Health/Drug/Alcohol Complete Medical Record
Other _____

To: **Angelina Caradonna, RD, LD, CLT**

The Purpose or need for this disclosure: Nutritional Consultation and Assessment

I UNDERSTAND that my records are protected under the Federal and State Law and cannot be disclosed without my written consent unless otherwise provided by law. I FURTHER UNDERSTAND THAT THE SPECIFIC TYPE OF INFORMATION TO BE DISCLOSED MAY, IF APPLICABLE, INCLUDE: DIAGNOSIS, PROGNOSIS AND TREATMENT FOR PHYSICAL OR PSYCHIATRIC ILLNESS, TREATMENT FOR ALOCHOL OR SUBSTANCE ABUSE, OR HIV TESTING.

I UNDERSTAND that I have the right to revoke this consent at any time by submitting a written and dated notice for revocation to the facility releasing this information. If not revoked this authorization is valid until ; otherwise expires ninety (90) days from the date signed below.

Signature of Patient or Legal Guardian (if minor):_____ Date:_____