AUTHORIZATION FOR RELAEASE 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: **Michal Hogan, 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:____Date:_____________________

Witness:____Date:_____________________