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The Nutrition Experts

AUTHORIZATION TO OBTAIN / RELEASE CONFIDENTIAL INFORMATION

I authorize ______________________________________ to:
(Nutritionist/Dietitian)

- Discuss my treatment progress
- To obtain medical records and/or progress notes
- To release medical records and/or progress notes

With/To/From the following individuals:

Primary Doctor

Name: ________________________________

Address: ________________________________

____

Phone: (____)______________

Email: ______________________________

Endocrinologist or Gynecologist

Name: ________________________________

Address: ________________________________

____

Phone: (____)______________

Email: ______________________________

Therapist or Psychiatrist

Name: ________________________________

Address: ________________________________

____

Phone: (____)______________

Email: ______________________________

Other (Personal trainer, fertility center, etc.)

Type of Professional: ____________________

Name: ________________________________

Address: ________________________________

____

Phone: (____)______________

Email: ______________________________

Type of Professional: ____________________

Name: ________________________________

Address: ________________________________

____

Phone: (____)______________

Email: ______________________________

I understand that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein.

Date: ____________________ Client Signature: ____

Address: ____

Nutritionist / Dietitian Signature: ______________________________