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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name_____ Date of Birth_____

I authorize my Registered Dietitian with Second Breakfast Nutrition to ____send ____receive protected healthcare information of the patient named above to:

Provider name:
Practice name:
Address:
Phone:
Fax:
Email:

This authorization applies to:
____all healthcare information ____other If other, specify:

The following information requires special request by law. Even if you indicate all health information, you must specifically request the following information in order for it to be released:
I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above. ___yes ____no

Patient Signature_____ Date_____