Sound Nutrition

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Authorization to Obtain/Release Confidential Information

Client's name:_____ Date of birth:_____
Client's address:_____
Phone number:_____

I authorize Sound Nutrition Counseling, PLLC to share/retrieve: ___ (initial) my treatment progress and ____ (initial) health care information/medical records with professional consultants and the following individuals:

☐ Primary Therapist
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
E-mail:_____

☐ Physician
Name: _____
Address: _____
_____
Fax: _____
Phone: _____
E-mail:_____

☐ Psychiatrist
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
E-mail:_____

☐ Other:_____
Name: _____
Address: _____
_____
Fax: _____
Phone: _____
E-mail:_____

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. I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, enrollment, or eligibility for benefits).

Effective Date: _____ Expiration date:_____

Client Signature: _____

Parent/Guardian Signature: _____