



AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the undersigned, hereby authorize the doctor or medical practice I name below to release the information specified to Nikki Drummond, CCN, at NeuroFit Nutrition.

Doctor's Name _____

Practice Name _____

Mailing Address _____

Phone Number _____

Fax Number _____

The reason for this release of information is: Continuity of care
 Other (please specify): _____

I understand that my records are confidential and cannot be disclosed without written authorization, except as otherwise provided by law.

This authorization is valid for six (6) months and may be revoked by the patient, orally or in writing at anytime prior to that expiration date.

Information to be released should include all history, physical exam and progress notes, lab and X-Ray reports, and all correspondence relating to my medical care unless otherwise specified below.
Your prompt attention is greatly appreciated.

Client's Printed Name

Client's Date of Birth

Signature of Client or Client's Legal Representative

Date

According to state and Federal law, the statements below must be signed in order to process your records requests if such information exists in your chart(s).

Please include the following information in my records request:

Mental Health Records

Signature of Client or Client's Legal Representative

Alcohol/Substance Abuse Records

Signature of Client or Client's Legal Representative

HIV Records

Signature of Client or Client's Legal Representative