SPEAKING OF NUTRITION, LLC

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Name:

Address:

Date of Birth:

Phone Number:

List any health professionals that I may communicate with in order to provide care.

Persons authorized to provide or receive Protected Health Information:

1)_____

2)_____

3)_____

Are there any other individuals that I may speak to about your care? Family members, spouse, etc.

1)_____

2)_____

3)_____

I authorize Speaking of Nutrition, LLC to use or disclose my protected health information

_____ Date_____

Signature of individual or legal representative

_____ Date_____

The Covered Entity may not use or disclose your protected health information except for purposes of treatment, payment, health care operations or other reasons permitted by law. You must authorize any other use or disclosure of your protected health information

l understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information

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