DC NUTRITION SERVICES

MEDICAL RECORD AND INFORMATION RELEASE

Authorization for Use or Disclosure of Protected Health Information

I authorize Maureen Gately/DC Nutrition Services to use and disclose protected healthcare information to the following providers:

- ☐ Name: _____Phone: _____
- ☐ Name: _____Phone: _____
- ☐ Name: _____Phone: _____

This authorization for release of information covers the period of healthcare from all past, present, and future periods.

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol and drug abuse). This medical information may be used by Maureen Gately/DC Nutrition Services for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

This authorization shall be in force and effect until the end of treatment with Maureen Gately/DC Nutrition Services, at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Name of client (printed): _____Date: _____

Signature of client/guardian:
_____Date:_____

Date of birth: _____

Street Address: _____ State: _____ Zip: _____