Adina Pearson Nutrition

Phone: 509-295-2923 - Fax: (509)396-5520

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: _____ DOB: _____

Address: _____ Telephone: _____

Email Address: _____

I hereby authorize: _____
(Individual/Agency)

_____
(Address)

_____
(City, State, Zip Code)

To communicate with the following individual/organization about my medical and nutrition care:

_____
(Individual/Agency)

_____
(Address)

_____
(City, State, Zip Code)

Permission to fax and/or send info electronically if necessary: _____ YES _____ NO

Please <u>do not</u> send medical records unless specifically requested. This signed release is only asking for permission to communicate about this patient. If records are requested they will be asked for separately.

This authorization will expire within 1 year. I may revoke this authorization in writing at any time, provided that the information has not yet been released.

_____
(Patient or Parent Signature) Date/Time