Release of Information Consent

Authorization to Exchange Confidential and Protected Health Information

This form will request Client Centered Nutrition, PLLC to send and receive confidential and protected health information to the individual(s)/provider(s) listed below.

Client Name _____**Date of Birth**_____
(MM/DD/YYYY)

I,_____ (client name), authorize Amanda Diede, MPH, RDN, CD and Client Centered Nutrition, PLLC to (check all that apply): ☐ **Disclose**

The following information:

☐ ENTIRE RECORD
☐ Diagnosis
☐ Treatment Plans
☐ Assessments
☐ Finances / billing
☐ Medications
☐ Progress notes, and treatment or closing summary
☐ Medical information (vitals, weight, labs, etc.)
☐ Other_____

To / From:

Name of Individual / Provider _____
Relationship to client_____
Phone Number _____ Fax Number _____
Address _____

Expiration:

This authorization will remain in effect for one year from the date signed, or until _____, whichever comes first. (MM/DD/YYYY)

I understand that this information may be protected by Title 42 (Code of Federal Rules of Privacy of Individually Identifiable Health Information, Parts 160 and 164) and Title 45 (Federal Rules of Confidentiality of Alcohol and Drug Abuse Patient Records, Chapter 1, Part 2), plus applicable state laws. I further understand that the information disclosed to the recipient may not be protected under these guidelines if they are not a health care provider covered by state or federal rules.

I understand that this authorization is voluntary, and I may revoke this consent at any time by providing written notice to Client Centered Nutrition, PLLC. I have been informed what information will be given, its purpose, and who will receive the information. I understand that I have a right to receive a copy of this authorization. I understand that I have a right to refuse to sign this authorization.

If you are the legal guardian or representative appointed by the court for the client, please attach a copy of this authorization to receive this protected health information.

Signature of Client_____ Date _____

Signature of Parent / Guardian_____ Date _____

Relationship to Client_____