Lutz, Alexander & Associates Nutrition Therapy

AUTHORIZATION TO OBTAIN / RELEASE CONFIDENTIAL INFORMATION

Client name _____ Date of birth _____

I, _____ authorize
(Client or Parent/Guardian if client under age 18)

- □ Anna M. Lutz, MPH, RD, LDN, CEDRD-S
- □ Shauna M. Alexander, RD, LDN, CEDRD
- □ Billie L. Karel, MPH, RD, LDN
- □ Lauren Buboltz, MPH, RD, LDN, CEDRD
- □ Antonia Hartley, MPH, RD, LDN
- □ Jocelyn Dantini, MS, RD, LDN

to:

- □ discuss treatment progress;
- □ obtain medical records and/or progress notes; and/or
- □ release medical records and/or progress notes

for myself/my child with the following individual(s):

Physician _____

Address _____ Phone _____

Therapist _____

Address _____ Phone _____

Other _____

Address _____ Phone _____

I understand that medical records and treatment are confidential and will not be disclosed without my written consent. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein.

Signature _____ Date _____

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