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)

Lutz, Alexander & Associates Nutrition Therapy and their Registered Dietitians to:

- □ discuss treatment progress
- □ obtain medical records and/or progress notes
- □ release medical records and/or progress notes
- □ discuss billing and financial information

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

Physician _____

Address _____Phone_____

Therapist _____

Address _____Phone _____

Other _____

Address _____ Phone _____

Purpose
The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation
I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Lutz, Alexander & Associates Nutrition Therapy at the office address below. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration
Unless sooner revoked, this authorization expires one year from today or as otherwise indicated: _____.

Conditions

I further understand that my dietitian with Lutz, Alexander & Associates Nutrition Therapy will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure

Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure

I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a State law applies that is more strict than HIPAA and provides additional privacy protections.

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.

_____ Date _____

Signature

_____ Date _____

Parent, Guardian or Personal Representative

If you are signing as a personal representative of an individual, please describe your authority to act for this individual (power of attorney, healthcare surrogate, etc.): _____