Nutrition with Heart

Courage • Connection • Grace

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Authorization to Release Medical Information

In effort to coordinate your healthcare Nutrition with Heart LLC is requesting your authorization to obtain and release your medical information. To facilitate this collaborative process please indicate which medical provider(s) may appropriately disclose and exchange your medical information with Nutrition with Heart LLC.

Patient Information:

Name:________________________ Birthdate:__________ Phone:__________

Address:____

Healthcare Provider Information *(please fill out to the best of your ability):*

Provider Name:____________________ Specialty:____________________

Office name:________________________ Phone:__________

Address:____

Fax:____________________ Email:____________________

Provider Name:____________________ Specialty:____________________

Office name:________________________ Phone:__________

Address:____

Fax:____________________ Email:____________________

Authorization:

☐ Medical Records from date of service: __________to: __________. ☐ Complete Medical Record

This medical information may be used by Nutrition with Heart LLC for medical treatment or consultation, billing and claims payment, or other purposes as I may direct. I understand that I have the right to withdraw this authorization at any time, and that such revocation must be in writing. 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 authorize Nutrition with Heart LLC to share, receive and disclose the protected health information described above. 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. Release of mental health [RCW 71.05], alcohol and drug abuse [RCW 70.96A; 42 C.F.R Part 2], sexually transmitted diseases, including HIV/AIDS [RCW 70.24], and certain minor treatment records may require specific patient authorization.

Purpose of Release: ☐ Continuing care ☐ Insurance ☐ Legal ☐ Other (specify): ____________

Federal and state laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains. A general release is NOT sufficient. 42 CFR Part 2: RCW 70.02.

Effective Period: This authorization does not expire until written notice of revocation has been provided.

Patient Signature:________________________ Today's Date:__________

Relationship if not Patient:____

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