AUTHORIZATION TO RELEASE AND DISCLOSE PATIENT INFORMATION (PHI)

Patient Information

Full Name:
Address:
City, State:
Date of birth:

Who has the information being requested?

Name of hospital, physician office, and/or home health agency:
Address:
City, State:

Information to be received by:
Holly A. Van Poots, RDN, CSP, FAND
bebalancedRDN@gmail.com
Fax: (800) 537-9182

Information to be released:
☐ **Growth charts**
☐ **Most recent well-child check up records**
☐ **Other: _____**

Purpose of release: Continuing Nutrition Care

I understand that:

- I can refuse to disclose some or all of the information in my record, but refusal may result in an improper diagnosis or treatment, denial of coverage for a claim for health benefits or other insurance or other adverse consequences.

- I can revoke all or part of this authorization at any time during this time period by providing written notice to the Health Information Management Department, **except** where this authorization already has been acted on for release of my protected health information. Such revocation may be the basis for denial of health benefits of other insurance coverage or benefits.

- I understand that if protected health information is disclosed to a third party, the information may no longer be protected by the federal or state privacy laws and may be re-disclosed by the individual or entity that receives this information.

- I understand I am entitled to a copy of this authorization, upon request.

This authorization is effective for one (1) year from the date of signing. I authorize future disclosures to the same individual and/or entity during this time period pursuant to this authorization.

_____

Signature of Patient or Authorized Representative Date

_____

Printed Name

_____

Relationship of Authorized Representative (e.g. Parent, Guardian, Power of Attorney)