AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION FOR MEDICAL NUTRITION THERAPY BY VERBAL AND/OR WRITTEN COMMUNICATION

I hereby authorize ***Patricia A. Ford, DrPH, MPH, RD***
to disclose information pertinent to my treatment status, diagnosis, nutrition status, to the following person(s) and/or organization(s).

1) Therapist _____
Address _____
Phone _____

2) Primary care MD _____
Address _____
Phone_____

3) Parents or guardians_____
Address _____
Phone _____

4) Other _____
Address _____
Phone _____

Patient Name _____
Date of Birth _____
SS#_____ Phone# _____

_____ _____ _____
Signature of Patient or Legal Representative (Relationship to Patient) Date

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