Imagine Wellness

PATTY ANN FORD

Authorization for release of protected health information for Medical Nutrition Therapy by verbal and/or written information

I hereby authorize Patty Ann Ford, DrPH, MPH, CEDRD to disclose information pertinent to my treatment status, diagnosis, nutrition status, to the following person(s) and/or organization(s):

1. **Therapist:** **Phone Number:**
   Address:

2. **Primary Care MD:** **Phone Number:**
   Address:

3. **Parents/Guardians:** **Phone Number:**
   Address:

4. **Other:** **Phone Number:**
   Address:

Patients Full Name:

Date of birth:

SSN:

Phone Number:

Relationship to Patient:

Signature of Patient or Legal Representative:

Client Signature **Date**