CLIENT AUTHORIZATION FORM (Release of Information)

If you would like Vita Nutrition Service's Dietitian's to communicate with your health care provider, caregiver or mental health professional feel free to fill out this form indicating their name and contact information. Thank you!

Name of Client_____Date_____

Hereby Authorize: Vita Nutrition Services To Release to:_____

I Hereby Authorize: _____

To Release to: Vita Nutrition Services

The Following: Laboratory results, recent office visit notes, past medical history, diagnostic reports & social, Other_____

Purpose of Disclosure: Medical Nutrition Therapy

I understand that the nature of this authorization is to release information and that I can revoke this consent at any time by written communication. The revocation of this consent will be effective the date it is received by the clinician.

I authorize this release of information until _____ (Date).

Client Signature and Date _____

Parent/Guardian/Legal Representative and Date _____

Clinician/Witness and Date _____

The recipient of these records is reminded that further disclosure of these records without client consent is prohibited.

Disclosure upon consent of a minor: A minor client 16 years or older receiving Medical Nutrition Therapy is to consent to the disclosure of his or her records in the same manner as an adult. Release of information expires after 1 year unless otherwise specified on this form.

Joanna Hunter Nutrition LLC DBA Vita Nutrition Services