Northern Nutrition

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Patient Authorization for Use/Disclosure of Protected Health Information

This form allows us to communicate with members or your health care team (physician, therapist, etc.) and/or friends or family members. It is recommended you list your referring and/or primary care physician on this form in the event our office needs to request chart notes, labwork, etc.

Patient Full Name: _____

I request and authorize *Northern Nutrition* to share (release and obtain from) health care information, both verbal and written, of the client named above with:

Name: _____Relationship: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

Name: _____Relationship: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

Name: _____Relationship: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

This authorization expires either one year from the date listed below or when the above named client or personal representative revokes this authorization in writing. I understand that I have the right to revoke this authorization at any time. However, my revocation will not have any effect on any actions *Northern Nutrition* took before she received the revocation. I understand that once *Northern Nutrition* releases the information, the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law.

_____ _____
SIGNATURE of client, client's representative, or parent **DATE**

_____
PRINTED NAME of client, client's representative, or parent