Dallas Nutrition Therapy

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name:_____ Date of birth:_____

Phone Number:_____ Social Security # (last 4):_____

I authorize _____ to release my medical information to ***Dallas Nutrition Therapy*** **Samira Amlani, RDN, LD.**

Information to be released:

- ❏ Complete Medical Records
- ❏ Visits & Encounters
- ❏ Laboratory Reports
- ❏ Other:_____

Deliver method:

- ❏ FAX
- ❏ Pick-Up records
- ❏ Mailing Records
- ❏ Other: _____

By State Law, you must be advised that : The information authorized for release may include record which may indicate the presence of a communicable or venereal records which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus also known as Acquired Immunodeficiency virus also known as Acquired Immune Deficiency Syndrome (AIDS)

- ❏ I further understand that this authorization will expire by law in 180 days from the date this authorization unless I otherwise specify.
- ❏ I further understand that i may revoke this authorization at anytime by notifying this practice in writing. I also understand that a written revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any actions taken before the receipt of the written revocation.

_____ _____

Signature of Patient, Parent or Legal Guardian **Date**

_____

Printed name of Patient,Parent or Legal Guardian