IDAHO NUTRITION ASSOCIATES

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Release of Information Authorization Form

Patient: _____ DOB: _____

I hereby authorize **Idaho Nutrition Associates** to release, obtain and/or exchange the following information in writing or by phone:

- Medical Records, including chart notes and lab results **from the past 12 months**
- Other: _____
- NO RECORDS NEEDED AT THIS TIME

Physician/Facility: _____

Address: _____

Phone: _____ Fax: _____

I understand that this consent, *unless specifically limited by me in writing below,* will extend to all aspects of treatment. This includes diagnosis of drug and/or alcohol abuse or psychiatric treatment.

_____

_____

Signature: _____ Printed: _____

Signature of Parent/Guardian (if a minor):_____

Date: _____ Expires: _____

Unless otherwise specified in writing this consent expires 90 days after nutritional services to the client are terminated. I understand I have no obligation to disclose the requested information, and I may revoke this consent at any time, except if action has been taken in reliance upon it, by informing Idaho Nutrition Associates in writing. I hereby release Idaho Nutrition Associates and its staff from all legal responsibility or liability which may arise from release of this consent of the person to whom it pertains. By my signature on this form I affirm that this consent is voluntary and freely given.