

Marci RD Nutrition Consulting Client Release of Information Form

READ FIRST: Before you decide whether or not to let Marci RD Nutrition Consulting share some of your confidential information with another agency or person, Marci RD Nutrition Consulting will discuss with you all alternatives and any potential risks and benefits that could result from sharing your confidential information. If you decide you want Marci RD Nutrition Consulting to release some of your confidential information, you can use this form to choose what is shared, how it's shared, with whom, and for how long.

I understand that Marci RD Nutrition Consulting has an obligation to keep my personal information, identifying information, and my records confidential. I also understand that I can choose to allow Marci RD Nutrition Consulting to release some of my personal information to certain individuals or agencies.

I, _____, authorize Marci RD Nutrition Consulting to share the following specific information with:

Who I want to have my information:	Name: Specific Office at Agency: Phone Number:
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The information may be shared: in person by phone by fax by mail by e-mail

I understand that electronic mail (e-mail) is not confidential and can be intercepted and read by other people.

What info about me will be shared:	<i>(List as specifically as possible, for example: name, dates of service, any documents).</i>
Why I want my info shared: (purpose)	<i>(List as specifically as possible, for example: to receive benefits).</i>

Please Note: there is a risk that a limited release of information can potentially open up access by others to all of your confidential information held by Marci RD Nutrition Consulting.

I understand:

That I do not have to sign a release form. I do not have to allow Marci RD Nutrition Consulting to share my information. Signing a release form is completely voluntary. That this release is limited to what I write above. If I would like Marci RD Nutrition Consulting to release information about me in the future, I will need to sign another written, time-limited release.

That releasing information about me could give another agency or person information about my location and would confirm that I have been receiving services from Marci RD Nutrition Consulting.

That Marci RD Nutrition Consulting and I may not be able to control what happens to my information once it has been released to the above person or agency, and that the agency or person getting my information may be required by law or practice to share it with others.

I understand that this release is valid when I sign it and that I may withdraw my consent to this release at any time either orally or in writing.

Signature: _____

Date: _____

RELEASE OF INFORMATION

(From Health Care Provider to Marci RD Nutrition Consulting)

Patient: _____

Health Care Provider:

Signature/Title _____

I, _____ (Patient/Legal Guardian) do hereby authorize the attending physician, the hospital or other health care agencies who will be providing care to release to Marci RD Nutrition Consulting any information related to the development, implementation and evaluation of my individual treatment plan, and to the payment of claims for services.

Information needed:

_____ (check if applicable) I consent to have any of my medical record information used for research purposes.

I understand that I should retain a copy of this signed release form and that a photocopy of this form is as valid as the original.

Signature: _____

Date: _____