Authorization for release of medical records

PATIENT INFORMATION (Please Print)

Name: _____

Date of birth (DD/MM/YYYY)**:** _____

Other / previous names: _____

Release my medical records

From:

Name: _____

Tel: _____

Fax: _____

To:

Nutriliciousbyz,
320 Decker Drive,
Suite #100,
Irving, Texas 75062.

Fax: +1-888-974-4238

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results, diagnostic tests and a list of currently prescribed medications.

Additionally, I authorize Nutriliciousbyz, LLC to communicate back to these physicians regarding my nutrition plan.

By my signature I authorize release of medical records to & from Nutriliciousbyz LLC:

Signature of patient / guardian _____

Date: _____

HIPPA: I have read and have access to the HIPPA (Health Insurance Portability and Accountability Act) policies.

Signature of patient / guardian _____

Date: _____