

ARIZONA NUTRITION SPECIALISTS



KRISTINE J. SCHIRM M.S., R.D.

REGISTERED DIETITIAN/NUTRITION THERAPIST

AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

I authorize _____ to _____

- Discuss my treatment progress
- To obtain medical records and/or progress notes
- To release medical records and/or progress notes
- With/to/from the following individuals:

Primary therapist

Dietitian

Physician

NAME: _____

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

ADDRESS: _____

PHONE: _____

PHONE: _____

PHONE: _____

Family member

Family Member

Family Member

NAME: _____

NAME: _____

NAME: _____

ADDRESS: _____

ADDRESS: _____

ADDRESS: _____

PHONE: _____

PHONE: _____

PHONE: _____

I certify that this release has been made freely, voluntarily and without coercion. I understand that this release will remain in effect and that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke my consent in writing at any time, except to the extent that action has been taken in reliance therein.

Date: _____

Client Signature: _____

Address: _____

Parent /Guardian signature: _____

Dietitian Signature: _____