

Nutrition Therapy Associates

3221 NW 13st Street, Suite D-2
 Gainesville, FL 32609
 352-371-8181; fax 352-379-5588

Authorization to Release Confidential Records/Information

Client: _____ Phone numbers: _____
 Address: _____ Home: _____
 _____ Work/school: _____
 Email: _____ Cell: _____

I authorize nutritionists at Nutrition Therapy Associates to release records and/or information to and to receive records/information from the following individuals. This authorization begins on _____ (date) and ends: in 12 months; or at the termination of treatment; or on _____ (date).

	Name	Address	Phone
Therapist			
Psychiatrist			
Physician			
Parents Spouse Other			

I have had explained and understand this request/authorization to release records and information. I understand that I can take back this consent in writing at any time. This consent will expire on the date I checked above.

 Signature Printed name Date

 Signature of parent/
 guardian/representative Printed name Relationship Date

 Signature of Witness Printed name Date

Copy for client/or parent/guardian Copy for source of information Copy for recipient of records