Authorization For Disclosure of Protected Health Information
Bluegrass Nutrition Counseling, Inc

Client's Name (please print):_____
First Name Middle Name Last Name

Date of Birth: _____

Today's Date: _____

Authorization Initiated by: _____
Name (client, provider, other)

Information to be Released:
ق all information related to treatment care of client

قselected information related to treatment care of client (please explain in detail)
_____
_
_____

Persons Authorized by this consent to receive information:

Name _____Relationship_____Phone_____
Name _____Relationship_____Phone_____
Name _____Relationship_____Phone_____

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of Client: _____

Signature of Parent/ Guardian (if under 18) _____

Date of Signature_____