Foundations
NUTRITION COUNSELING

www.foundations-nutrition.com
919-307-7414

Authorization to Obtain / Release Confidential Information

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

I, _____, whose Date of Birth is _____, authorize
[Name of Client]
Rachel Aiken of Foundations Nutrition Counseling, to: (check all that you agree to)

____ discuss treatment progress;
____ obtain medical records and/or progress notes; and/or
____ release medical records and/or progress notes

for myself/my child with the following individual(s):

Physician _____

Practice _____ Phone _____

Therapist _____

Practice _____Phone _____

Other _____

Practice _____ Phone _____

I understand that medical records and treatment are confidential and will not be disclosed without my written consent. I also understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Rachel Aiken. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

_____ Date: _____
(Signature of client or parent/guardian if client under age 18)