LE-NUTRITION LLC **Lauren McCarthy, MS, RD, LD, IFNCP**

Authorization for Disclosure of Health Information to Lauren McCarthy, MS, RD, LD, IFNCP

I hereby authorize _____ to release medical information from the records of:
(Name of Practitioner/Facility)

Patient Name: _____ Date of birth: _____

Patient Home Address: _____

Date(s) of Treatment Requested: _____

Information to be disclosed (check ALL applicable items to be released):

- [ ] Discharge summary
- [ ] ER record
- [ ] Progress notes
- [ ] Treatment Plans
- [ ] Discharge instructions
- [ ] X-ray reports
- [ ] Medication records
- [ ] Commitment papers
- [ ] Therapy notes
- [ ] Other (please specify): _____
- [ ] History and physical
- [ ] Lap reports
- [ ] Doctor's orders
- [ ] HIV testing
- [ ] Consultations
- [ ] EKG/ECK reports
- [ ] Nurse's notes
- [ ] Operative report

Purpose or Need for the disclosure is (please select):
[ ] Patient's Own Use [ ] Continued medical care [ ] Insurance or legal [ ] Other _____.

The information may be disclosed to: Lauren McCarthy, MS, RD, LD, IFNCP DBA LE-Nutrition LLC
Mailing Address: 6313 Lake Worth Blvd #1029 Lake Worth, TX 76135
Phone: 682-235-9884 **Fax**: 682-316-9294

My refusal to sign this form will not adversely affect my ability to receive health care services, reimbursement for services, and enrollment in a health plan or my eligibility for health benefits. I acknowledge that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by Federal Law. I have the right to revoke this authorization by written notice to the healthcare provider listed above. I understand that actions taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions.

This authorization expires on: _____ or upon the following event: _____.

I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted diseases, AIDS, AIDS related complex and/or HIV.

_____
Signature of Patient Date of Signature

_____
Printed Name of Patient

The information above is Protect Health Information (PHI), and is the minimum necessary to execute delivery of patient services. Please understand as a link in the "Chain of Trust," all PHI will remain confidential as mandated by the Treatment, Payments, and Healthcare Operation Laws mandated by HIPPA.