

MEDICAL RELEASE AUTHORIZATION

Lora Williams, MS, RD, LD
Full Circle Nutrition
www.fullcirclenutrition.com
(940) 536-4433
(940) 380-9139 (fax)

AUTHORIZATIONS:

I understand that as part of my healthcare, Full Circle Nutrition maintains records describing my health history, symptoms, dietitian examination / assessment, test results submitted by your doctor, recommended treatment, and plans for future care and treatment. All health records are retained and secured for privacy in accordance with the Privacy Act of 1974 and HIPPA.

Signature of Patient / Legal Guardian /
Patient Representative

Printed Name

Date

Relationship if not the patient

MEDICAL RELEASE

I hereby authorize _____ to release available current laboratory data contained in my patient records to Lora Williams, MS, RD, LD for clinical evaluation.

Participant Name (print): _____ Telephone: _____

Street: _____

City: _____ State: _____ ZIP: _____

This consent is subject to revocation at any time except to the extent the action has been taken thereon.

*Signature of Patient / Patient's Personal Representative***

Printed Name

Date Signed

Relationship if not Patient