MEDICAL RELEASE AUTHORIZATION
From
FULL CIRCLE NUTRITION

Lora Williams, MS, RD, LD
121 W. Hickory St. Ste 101
Denton, TX 76201
(940) 536-4433
(210) 547-9477 (fax)

I hereby authorize Lora Williams, MS, RD, LD of Full Circle Nutrition to release all nutrition consult reports and _____ to:

Name _____ Telephone_____

Address _____ City/State/ Zip_____

Reason / Purpose for release: *(please circle)* personal records; Specialist; Insurance; Other_____

Please also release my nutrition consult report to the person(s) listed here: _____

_____ _____ _____ _____
Street Address or PO Box City State Zip

Expiration: This authorization will expire on (must choose one):

☐ One year from the date it is signed ☐ Other (insert date or event):_____

Right to Revoke: I understand that I may revoke this authorization at any time by giving written notice to the address listed at the top of this form. I understand that revocation of this authorization will not affect any action the above named entity took in reliance on this authorization before the above named entity received my written notice of revocation.

Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

_____ _____ _____
*Signature of Patient / Patient's Personal Representative*** *Printed Name* *Date Signed*

_____
Relationship if not Patient

_____ _____ _____
Witness *Printed Name* *Date Signed*

Reviewed / revised 1/2011

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