MEDICAL RELEASE AUTHORIZATION

I hereby authorize **Doctor / Provider / Practice / Hospital** _____

Phone _____ Address:_____

City/ State/Zip: _____

To release available MNT related / current

___ laboratory data
___ growth charts, weight records
___last medical record pertinent to medical nutrition therapy

contained in my patient records **TO:** Lora Williams, MS, RDN, LD, CDCES, of Full Circle Nutrition

for clinical evaluation and Medical Nutrition Therapy Services

FOR: Patient Name: _____ DOB_____Phone: _____

Address: _____ City/ State/Zip: _____

Address (if different than above)_____

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

Send or Fax records to:

Full Circle Nutrition
(940) 380-8788 (Confidential Fax)
www.fullcirclenutrition.com

721 N. Locust St.
Denton, TX 76201
(940) 380-8780 (phone)

Reviewed / revised 4/2020