LEXSTART NUTRITION

Authorization Release/Request Health Information

Client's name: (First, Middle, Last) _____

Date of Birth (MM/DD/YY):_____

Today's Date (MM/DD/YY):_____

Authorization Initiated by Name (client, provider, other) :_____

Information to be released:

- ☐ **Personal health information related to treatment of client;**
- ☐ **Selected information related to treatment of client.** (Please Explain:)

_____
_____
_____

Information to be released or received:
Contact Name_____
Contact Facility/Practice _____
Contact Relationship _____
Contact Address _____
Phone: Business _____Cell_____
Fax _____
Email Address_____
Purpose for Release of Information:_____

I hereby authorize LexStart Nutrition, LLC to release/receive information from the following health care providers via verbal, mail and/ or fax communication. I understand that the following types of protected health information may be used, disclosed, and retained by the health care providers as a result of the communications. I understand that authorization is voluntary, that the information to be disclosed is protected by law and the use/disclosure is to be made to conform to my directions.

Signature of Client:_____

Signature of Parent/Guardian (if under 18):_____

Date of Signature:_____(MM/DD/YY)

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