

Patient Authorization for Use/Disclosure of Protected Health Information

This form allows me to communicate with members or your health care team (physician, therapist, etc.) and/or friends or family members.

Client name (print): _____

I request and authorize Libby Hugo, RDN, CDE to share (release and obtain from) health care information, both verbal and written, of the client named above with:

Name: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ **Fax:** _____

Name: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ **Fax:** _____

Name: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ **Fax:** _____

This authorization expires either one year from the date listed below or when the above named client or personal representative revokes this authorization in writing. I understand that I have the right to revoke this authorization at any time. However, my revocation will not have any effect on any actions Libby Hugo, RDN, CDE took before she received the revocation. I understand that once Libby Hugo, RDN, CDE releases the information, the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law.

Signature of client, client's representative, or parent

Date

Printed name of client, client's representative, or parent