Authorization to Release or Request Medical Information

Patient's name: _____Date of Birth_____

Street Address: _____

City: _____Zip Code: _____

Patient's SS #_____Email address: _____

Phone Number: (home)_____(cell)_____(work)_____

Permission is herby given for Maria Larkin, M.Ed. RDN, LD of *Better Gut Better Health, LLC* to release or request information about this patients medical, nutritional or psychotherapeutic record from:

Practitioner's name_____

Address_____

Fax_____Phone_____

☐ Physician/nursing notes	☐ Sexual assault
☐ Laboratory tests	☐ Mental health
☐ Complete health record	☐ Drug/alcohol
☐ History and physical exam	☐ Growth charts/weight history

I hereby release Maria Larkin, M.Ed, RDN, LD of *Better Gut Better Health, LLC* from any liability or legal responsibility in connection the release of this information. I understand the risks of faxing and emailing medical information. I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I understand that the potential for information disclosed pursuant to this authorization is subject to re-disclosure by the recipient other than Maria Larkin, which would be beyond the control of Maria Larkin and may no longer be protected by federal law.

I request that the following information **not** be released: _____

_____

Patient, parent or guardian signature_____

Date_____Witness_____

Better Gut Better Health, LLC
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