# Nutrition ExChange LLC

# Authorization for Release of health information

Name:       Date of Birth:

Phone Number:

Address:       City:       State:       Zip:

List any **health professionals** that I may communicate with in order to provide care.

**-Physicians or other health care professionals authorized to provide or receive Protected Health Information:**

1. Name:       Phone Number:

Address:

Fax Number:

1. Name:       Phone Number:

Address:

Fax Number:

1. Name:       Phone Number:

Address:

Fax Number:

List any other individuals that I may speak to about your care? Family members, spouse, etc.

1)       Phone Number:

2)       Phone Number:

3)       Phone Number:

The Covered Entity may not use or disclose your protected health information except for purposes of treatment, payment, health care operations or other reasons permitted by law. You must authorize any other use or disclosure of your protected health information.

l understand that this authorization is voluntary and that I may revoke it at any time by submitting my revocation in writing to the entity providing the information.

**I authorize Nutrition ExChange, LLC to use or disclose my protected health information**

Name:       Date:

Signature of individual or legal representative

      Date: