SANDY ZOHNI *MS RD CDN CDE*

MEDICAL RELEASE CONSENT FORM

PATIENT NAME:

_____

DATE OF BIRTH:

_____

THE INFORMATION YOU MAY RELEASE INCLUDES ALL MEDICAL RECORDS AND NOTES REGARDING MY CARE AND TREATMENT, AS WELL AS LAB AND/OR TEST RESULTS.

YOU MAY RELEASE MY HEALTH AND MEDICAL RECORDS TO THE FOLLOWING HEALTH CARE PROFESSIONAL/PERSON/FACILITY/ENTITY AND/OR THOSE ASSOCIATED IN MY MEDICAL CARE:

NAME:

_____

FULL ADDRESS:

_____

_____

BY SIGNING THIS FORM, I AUTHORIZE YOU TO RELEASE CONFIDENTIAL HEALTH INFORMATION REGARDING MY TREATMENT AND CARE.

CLIENT NAME:

_____

CLIENT SIGNATURE:

_____

DATE:

_____