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Authorization for Release of Information

I authorize Dandelion Nutrition to share/retrieve my treatment progress and health care information/medical records with professional consultants and the person(s) listed below.

I understand that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time by providing a written request.

Name_____ Relationship_____

Location_____

Phone_____ Fax_____

Other Contact Info_____

Name_____ Relationship_____

Location_____

Phone_____ Fax_____

Other Contact Info_____

Name_____ Relationship_____

Location_____

Phone_____ Fax_____

Other Contact Info_____

Patient Name_____ Date of Birth_____

Patient Signature _____ Date _____

Responsible Party for minors under the age of 18:

Signature _____ Date _____

Printed Name _____ Relationship _____