Authorization to Release Medical Healthcare Information & Records

Naturally Optimal – Medical Nutrition, Massage, & Bodywork
778 Lois Drive, Sun Prairie, WI 53590
Phone: 608.658.5027 Fax: (608) 820-2403

(Please Print)

Client Information

Last Name:		First:	Middle:
Street address:			Birth date:
City:	State:	ZIP Code:	Phone no.: ( )

Medical Records Released from

Name:			
Institution:			
Street address:			Phone no.: ( )
City:	State:	ZIP Code:	Fax no.: ( )

Released of Information to Naturally Optimal

I permit to release any and all pertinent health and medical information including diagnoses, tests, lab reports, prescriptions, procedures, and notes to **Alise Dobrot, MS, RDN, LDN, LMT** at **Naturally Optimal**.

Please check delivery options:

☐ Mail to Address: 778 Lois Drive, Sun Prairie, WI, 53590
☐ Fax to Naturally Optimal: (608) 820-2403
☐ Hold for patient Pickup

Authorization & Timeframe of Release

Please check each to verify that by signing this authorization the patient understands:

☐ I have the right to receive a copy of this authorization.
☐ I authorize the disclosure of my identifiable health information as described above.
☐ I have the right to terminate this authorization and revoke permission to release information. The revocation must be made in writing and will not affect information that has already been disclosed.
☐ I understand that the person to whom my medical information is disclosed pursuant to this agreement may not further use or disclose the information unless another authorization is obtained from me or unless such disclosure is required by law.
☐ I am signing this authorization voluntarily.

Client/Guardian Signature:	Release Date:

Please keep a copy of this release for your records.