Authorization to Release Medical Healthcare Information & Records

Naturally Optimal – Medical Nutrition, Massage, & Bodywork
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(Please Print)			
Client Information			
Last Name:		First:	Middle:
Street address:			Birth date:
City:	State:	ZIP Code:	Home phone no.: ( )
Health Care Information & Record Released To			
Name:			
Institution:			
Street address:			Phone no.: ( )
City:	State:	ZIP Code:	Fax no.: ( )
Types of Information Released			

I permit Naturally Optimal to release the following health care information to the person/entity listed above. I understand that Naturally Optimal needs my written authorization to release any health care information about nutrition or massage related notes taken during client visits. This may include previously shared information to Naturally Optimal that may be in client notes such as testing, diagnosis, procedures and/or treatment for alcohol and/or chemical dependency, reproductive health, sexually transmitted diseases (including HIV/AIDS), genetic information or psychiatric disorders/mental illness. Based on the box(es) I have checked below, Naturally Optimal may release all notes, diagnostic, procedural, claim, prescription or other related information and records.

☐ General Health Care	☐ Sexually Transmitted Diseases
☐ Alcohol and/or Chemical Dependency	☐ Reproductive Health (including Abortion)
☐ Psychiatric Disorders/Mental Illness	☐ Genetic Information
☐ Specific Condition/Problem or Other:	

Purpose for Release of Information and How It Will Be Used

☐ At the request of another individual or institution		
☐ At the request of the Company for:	☐ Research	☐ Marketing
☐ Other (please state specific date, specific time period, event or condition):		

Authorization & Timeframe of Release

Unless I revoke it, this release will remain valid for 90 days from the date of my signature below. I understand that I may change my mind and revoke this release at any time. I will do this by letting Naturally Optimal know of my decision in writing. Any change will be effective five (5) business days after Naturally Optimal receives my written notice at the address listed at the top of this form. I understand that some or all of this information may already have been shared and that Naturally Optimal will not be liable for any information already released.

Client/Guardian Signature:	Release Date:

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

Please keep a copy of this release for your records.