Personalized Nutrition For The Whole You

SIMPLICITY NUTRITION

HIPAA MEDICAL RELEASE OF INFORMATION FORM

I, _____ (Print name), whose date of birth is _____, authorize the practitioners of Simplicity Nutrition, Inc to disclose to _____ (Print name, Relationship to client), the following information:

Description of Information to Be Disclosed (please check all that apply):

___Nutrition Assessment
___Diagnosis
___Treatment Plan
___Testing/Body Composition Information
___Progress in Treatment

Purpose:

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services.

Revocation:

I understand that I have the right to revoke this authorization, in writing, at any time by sending written notification to Simplicity Nutrition at PO Box 1401, Snoqualmie, WA 98065. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Expiration:

Unless revoked, this authorization does not expire.

I will be given a copy of this authorization for my records.

_____

Signature of Client **Date**

_____

Signature of Staff Witness **Date**