

## **Authorization for Obtaining or Releasing Confidential Information**

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Home Address: \_\_\_\_\_

Authorize Kellie Berry Nutrition, Inc. to Obtain/Release: Verbal communication, medical records, treatment progress notes and/or discharge summaries to/From Organization and/or person:

\_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_

Fax number: \_\_\_\_\_

I hereby authorize Kellie Berry Nutrition, Inc. to release/obtain copies of psychiatric, drug and alcohol, and Medical information from the health care record pertaining to my hospitalization/treatment of ALL DATES by mail, telephone conversation, or facsimile transmittal to or from.

These records are required for Providing Information to health care providers.

By signing below, I understand that my treatment and payment for treatment will not be affected if I do not sign this form and I am entitled to a copy of this form after I sign it. I acknowledge that this consent is voluntary. I further acknowledge that this authorization is subject to revocation in writing except to the extent that action based on this consent has already occurred. I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that this authorization will expire exactly one year from the date of my signature below.

If you agree: I certify that this form has been fully explained to me and that I understand its contents:

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

If you choose to refuse: I hereby acknowledge that I have been asked to sign the above release of Confidentiality Information and choose to refuse permission.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_