NUTRITIOUS thoughts

31 College Place, Building B, Suite 200, Asheville, NC 28801
Phone: (828) 333-0096 Fax: (828) 505-8772

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Client Name (print):_____ **Date of Birth:**_____

Other Names Used:_____

*Parent/Guardian/Legal Representative Name (minors only):*_____

Health Care Provider, Person, Agency or Emergency Contact Information: Please provide the name, relationship (e.g. PCP, mother, etc.) and contact information of the provider, person, agency or emergency contact that Nutritious Thoughts can communicate, request information, or send information to.

Name	*Relationship*	*Phone*	*Name*	*Relationship*	*Phone*
Name	*Relationship*	*Phone*	*Name*	*Relationship*	*Phone*
Name	*Relationship*	*Phone*	*Name*	*Relationship*	*Phone*
Name	*Relationship*	*Phone*	*Name*	*Relationship*	*Phone*

I authorize Nutritious Thoughts to be able to communicate, request, and/or send the following information to the providers, persons or agencies listed above:

- ✓ Intake Evaluation/Assessment
- ✓ Progress Notes/Treatment Plans
- ✓ Financial Info/Scheduling
- ✓ Discharge Summaries
- ✓ Ongoing Verbal Communication
- ✓ Continuity of Care

Statement of Authorization: I understand that my consent will remain in effect as long as I am a client of Nutritious Thoughts, LLC, unless and until I notify Nutritious Thoughts in writing of any changes or authorization expires upon the minor's age of majority. I have been informed what information will be released, its purpose, and who will receive the information and I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand and authorize that the disclosure may include information on diagnosis and treatment, AIDS or HIV infection, drug or alcohol abuse or genetic testing. I understand that personal health information, once disclosed, might be re-disclosed and is no longer protected by federal privacy regulations. I also understand that I may refuse to sign this authorization. Nutritious Thoughts will not condition treatment, payment, enrollment or eligibility for services based on whether I sign this authorization. **BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM.**

Client Signature **Parent/Guardian/Representative Signature** **Date**

Legal Representative *(where applicable)**:** I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.*

Representative Signature *Relationship to Client/Legal Authority* *Date*