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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security #: _____

I request and authorize _____ to release healthcare information of the patient named above to:

Name: Olabisi A. Daramy, MS. LDN. CNS/Spirituality & Wellness Nutrition Consultant

Address: 6495 New Hampshire Avenue, Suite 307

City: Hyattsville State: MD Zip Code: 20783

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ Other: _____

Definition: Health and Nutrition Status: **Anything related to blood chemistry; The digestive system; Hereditary Conditions such as diabetes, (A1c, 2 hr. PP test), high blood pressure, Lipid Panel (Tot. Cholesterol, LDL, HD**L, **Triglycerides, CBC, CMP etc……..HIV (Human Immunodeficiency Virus), AIDS (Acquired Immunodeficiency Syndrome)**

☐ Yes ☐ No I authorize the release of any records pertaining to my blood chemistry and treatment of my physical and nutritional Status

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.