COLLABORATION WITH OTHER PROVIDERS

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Reason for Collaboration: ______________________

Contact Number: ______________________ Email Address: ______________________

Insurance: ______________________

I request and authorize Tabitha Lenox, M.S., R.D.N., L.D. to collaborate with:

Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip Code: __________

Fax: ______________________ Phone: ______________________

☐ Healthcare information relating to the following treatment/conditions: ______________________

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☐ Insurance provider details as needed for treatment and continuation of care.

☐ Other: ______________________

☐ Yes ☐ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person (s) listed above.

☐ Yes ☐ No I authorize the collaboration and sharing of any health information pertaining to my continuation of care between the persons and entities listed above.

Patient Signature: ______________________ Date Signed: ______________________

Guardian (<18yrs) ______________________ Date Signed: ______________________

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