

**AUTHORIZATION TO SHARE HEALTHCARE INFORMATION**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Previous Name: \_\_\_\_\_

I request and authorize Tabitha Lenox, M.S., R.D., L.D. to release healthcare information to:

Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Fax: \_\_\_\_\_ Phone: \_\_\_\_\_

Healthcare information relating to the following treatment/conditions: \_\_\_\_\_  
\_\_\_\_\_

Information to my insurance provider as needed for treatment.

All healthcare information

Other: \_\_\_\_\_

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

Patient Signature: \_\_\_\_\_ Date Signed: \_\_\_\_\_