AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Client	
Address	
Phone Number	**Birth Date**
Email	
Other Names Identified By/Aliases	

I hereby authorize the following health care company to release all health information about me.

Organization to Release Information Summit Performance Nutrition LLC		
Street Address 6156 Rockville Drive		
City Colorado Springs	**State** Colorado	**Zip Code** 80923
Phone Number (719) 684-5754	**Email** SummitPerformanceNutrition@gmail.com	

The following health information that relates to service beginning from December 7th, 2018 may be released.

- Entire medical record [including patient name, image, histories, office notes (except psychotherapy notes), test results, radiology studies, films, referrals, consults, billing records, insurance records, and records sent by other health care providers.]

The above person/organization, its employees, representatives and any other persons performing services for them or on their behalf, may need to obtain, use or disclose any and all information about my physical and mental health, including but not limited to:

- services for preventative, diagnostic and therapeutic care, tests, counseling, and medical prescriptions.

This authorization is valid for 1 year following the date of my signature shown below. A copy, electronic copy, image, or facsimile of this authorization is as valid as the original. I have the right to revoke this authorization in writing at any time. I acknowledge that such a revocation is

not effective to the extent the above person/organization has relied on the use or disclosure of my health information.

I understand and agree that health information about me, which is used or disclosed pursuant to this authorization, may be subject to re-disclosure by the recipient and may no longer be protected by law.

By my signature below, I acknowledge that any prior agreement I have made to restrict or limit the disclosure of information about my health does not apply to this authorization.

I have read (or have had read to me) this authorization, and I agree to its terms as indicated by my signature below. I am entitled to a copy of this authorization.

_____

Patient's Signature

_____

Patient's Name

_____

Date