Authorization to Release Medical Records

Please complete this form as soon as possible so that have time to request a copy of your medical records from your doctor prior to your appointment. Access to your medical records is an important part of Medical Nutrition Therapy. It enables us to give you the most appropriate and customized nutrition recommendations and may be necessary to bill insurance, which requires us to bill using accurate medical diagnosis codes from a physician.

Personal Information

Legal first name

Last name

Date of birth

I would like the following information to be disclosed to Lifestyle Nutrition WNY, PLLC WITHIN 3 business days of my request:

_X_ All complete and recent bloodwork

_X_ Most recent MD annual physical and progress note(s)

_X_ All previous Dietitian notes on file

_X_ Nutritionally pertinent films and reports

_X_ In addition to the items above, any additional records specifically requested by receiving provider's office

Please fax records to: (716) 794-9466

The purpose of this disclosure is: Continuity and collaboration of care between medical providers.

Authorization for Lifestyle Nutrition WNY, PLLC to Release/Receive Medical Records from the following Authorized Person/s:

Authorized Provider/s

(Please include your Primary Care doctor and any specialists that you would like us to send/receive records to/from, for example, Nephrologist, Endocrinologist, etc.)

Title

Legal first name

Last name

Street

Unit

City

State/Province

Postal code

Work phone

Mobile phone

Fax number

Email address

Title/Occupation

Authorized Provider/s

(Please include your Primary Care doctor and any specialists that you would like us to send/receive records to/from, for example, Nephrologist, Endocrinologist, etc.)

Title	Legal first name	Last name

Street	Unit

City	State/Province	Postal code

Work phone	Mobile phone	Fax number

Email address

Title/Occupation

Client

X

Print name: **Date:**