Northern Nutrition

1125 E Polston Ave, Suite A
Post Falls, ID 83854
Phone: (208) 640-4502
Fax: (208) 777-7330
Email: admin@northernnutrition.net
Web: www.northernnutrition.net

Patient Authorization for Use/Disclosure of Protected Health Information

This form allows *Northern Nutrition* to communicate with members or your health care team (physician, therapist, etc.) and/or friends or family members. **It is recommended you list your referring and/or primary care physician on this form in the event our office needs to request chart notes, labwork, imaging, etc.**

I request and authorize *Northern Nutrition* to share (release and obtain from) health care information, both verbal and written, of the client named above with:

Name: _____ **Relationship:** _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

Name: _____ **Relationship:** _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

Name: _____ **Relationship:** _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

This authorization expires either one year from the date listed below or when the above-named client or personal representative revokes this authorization in writing. I understand that I have the right to revoke this authorization at any time. However, my revocation will not have any effect on any actions *Northern Nutrition* took before they received the revocation. I understand that once *Northern Nutrition* releases the information, the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law.

_____ _____ _____

SIGNATURE (client, client's representative, or parent) **PRINT NAME** **DATE**