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## **AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS**

### **PATIENT INFORMATION (Please Print)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Any Previous Names: \_\_\_\_\_

### **RELEASE MY MEDICAL RECORDS FROM:**

NAME: \_\_\_\_\_

TEL: \_\_\_\_\_

FAX: \_\_\_\_\_

To: Nutriphasics, LLC  
555 Republic Drive, Suite 200  
Plano, TX 75074  
Fax: 888-821-2292

Please release a copy of all my medical records, including but not limited to, progress notes, operative notes, laboratory results, diagnostic tests, and a list of currently prescribed medications.

### **BY MY SIGNATURE I AUTHORIZE RELEASE OF MEDICAL RECORDS**

Patient: \_\_\_\_\_ Date: \_\_\_\_\_  
(Legal Guardian if under 18 years of age)

**HIPPA:** I have read and have access to the HIPPA (Health Insurance Portability and Accountability Act) policies.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Legal Guardian if under 18 years of age)