Dalit Szkolnik, MA, RD, LD/N, CEDRD-S

Registered Dietitian

Authorization for Release/Request of Protected Health Information

Patient Name: _____DOB (mm/dd/yy): _____

Parent/Guardian: _____ (Applies only to patients under 18 years of age)

I Authorize Dalit Szkolnik to Release/Receive information from:

Contact Name: _____ Contact Relationship: _____

Address:

_____

Phone: _____ Fax: _____ Email Address: _____

Contact Name: _____ Contact Relationship: _____

Address:

_____

Phone: _____ Fax: _____ Email Address: _____

Purpose for Release of Information: ☐ Continuity of Care ☐ Other: _____

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: One year from patient signature on this form.

Dalit Szkolnik is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Signature of Patient: _____Date Signed: _____

Signature of Parent/Guardian: _____Date Signed: _____