TEL 650.796.1505 FAX 650.251.4377 EMAIL KATHRYNLBROWN@GMAIL.COM
WWW.KATBROWNNUTRITION.COM

# Authorization for Release of Information

| Full Name | |
|---|---|
| Date of Birth | Age |
| If under 18, parent or guardian name | |
| Address | |
| Email address | |
| Primary phone # ☐ cell ☐ home ☐ other | |

I, ______________________________________, give permission to Kat Brown to:
☐ use the following protected health information, and/or
☐ disclose the following protected health information to:
Primary Care MD_______________________________ phone #___________________________
Specialist MD__________________________________phone #____________________________
Therapist/Mental Healthcare
Provider____________________________phone#________________________________________
Family Therapist________________________________phone#___________________________
Psychiatrist_____________________________________phone #__________________________
Other__________________________________________phone #___________________________

This release is reciprocal for all above providers ☐ yes ☐ no, if not, for whom is the release reciprocal?
__________________________________________________________________________________

Information not to be disclosed (if any): _________________________________________________
__________________________________________________________________________________

Information will not be released without a valid signature below.

I can cancel this authorization in writing at any time. I understand that Kat Brown will continue to provide care, even if I do not authorize this release.

Patient signature: Date:
Parent/Guardian signature: *(under 18)* Date: