Laurie McDonald
Nutrition

Receipt of HIPAA Notice & Release of Medical Records

Client's written acknowledgement confirming receipt of privacy notice
I understand that under the Health Insurance Portability and Accountability Act (HIPAA) of 1998, I have certain rights to privacy in regard to my protected health information (PHI). I have received, read and understand the HIPAA Notice of Privacy Practices provided by Laurie McDonald Nutrition, LLC.

_____ _____
Client Signature Date

Authorization to Release Medical Records
I authorize the use and disclosure of my protected health information as described below to Laurie McDonald Nutrition, LLC.

Physician Name:_____
Address: _____
Phone: _____
Specialty: _____ (if applicable)

Physician Name:_____
Address: _____
Phone: _____
Specialty: _____ (if applicable)

Effective Period
This authorization for the release of information covers the period of healthcare of all past, present, and future periods.

Extent of Authorization
I authorize the release of my complete health record with the **exception** of the following information:
- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse & treatment

Agreement
I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Client printed name: _____ Date of birth: _____
Client Signature: _____ Date: _____
Guardian Signature if client under age 18: _____