

**Release of Protected Health Information (PHI)**

Name of Client: \_\_\_\_\_

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

I hereby authorize the release and exchange of information between  
Jennifer Hanlin, MS, RD, MFT and the following health care professional, agency, or institution:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

This authority extends to the furnishing of copies of all or any desired portions of the records pertaining to the above named client.

Jennifer Hanlin and the individual, agency, or institution named above are hereby released from all legal liability that may arise from this exchange or release of information.

I understand that I may revoke this consent at any time by informing all of the above parties in writing.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Patient

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Parent or Guardian