

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