Dr. Emily Gutierrez, DNP, CPNP **Jana Roso, CPNP**

MEDICAL RECORDS RELEASE

Please complete the following information:

_____ _____
Patient Name **Date of Birth**

_____
Address **City/State/Zipcode**

_____ _____
Phone Number **Guardian Name**

I hereby authorize disclosure or use of protected health information including but not limited to: Office Notes, Plan of Care, Laboratory/Pathology Results, and Prescription Record between Neuronutrition Associates and the following:

_____ _____
Name of Healthcare Provider **Office Name**

_____
Address **City/State/Zipcode**

_____ _____
Phone Number **Fax Number**

**Note: If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

I understand that after the custodian of records discloses my health information, it may no longer be protected by federal privacy laws. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment; receive payment; or eligibility for benefits unless allowed by law. By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information. I understand that I have the right to revoke this request at any time by contacting Neuronutrition Associates at the address below. This request is due to expire: _____.

_____ _____
Guardian Signature **Date**

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