Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Cynthia Palmerino, MS, RD, CLC (hereby referred to as the Practice) to use and/or disclose certain protected health information (PHI) about me to (name/address):

_____

Name of Insurance

_____ _____

Name of Doctor **Address**

This authorization permits the Practice to use and/or disclose the following individually identifiable health information about me: nutritional assessment and/or fitness recommendations, and progress reports, including date(s) of service and type(s) of service(s).

The information will be used or disclosed for the following purpose: to file insurance claims; to provide nutrition and fitness assessments and progress notes as part of health promotion efforts.

This authorization will expire on: _____.

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from the Practice. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). I have the right to revoke this authorization in writing except to the extent that the Practice has acted in reliance upon this authorization. My written revocation must be submitted to Cynthia Palmerino at:

8237 Chancery Ct, Alexandria, VA 22308

Signed by: _____ _____

Signature of Patient or Legal Guardian Relationship to Patient

_____ _____

Print Patient's Name Date

_____

Print Name of Legal Guardian, if applicable