EAT WELL WITH GINA, LLC
AUTHORIZATION FOR
RELEASE OF INFORMATION

I, the undersigned patient or legal guardian, hereby understand that different medical practitioners and agencies offer many different services and benefits. To provide the best service, each agency or office requires specific information to provide these benefits. By signing this form, I am allowing agencies/medical practitioners to release and exchange information so it will be easier for them to work together to provide the best possible service and care.

I authorize: ___ verbal, ____ written information to be __released by, ___received by, or ___exchanged between: Gina Consalvo, MA, RD, LDN, NCC of Eat Well with Gina, LLC and the following individuals:

PHYSICIAN/SPECIALIST	
NAME:	
ADDRESS	
CITY/STATE/ZIP:	
PHONE:	FAX:
THERAPIST / SPECIALIST	
NAME:	
ADDRESS	
CITY/STATE/ZIP:	
PHONE:	FAX:
FAMILY MEMBER or OTHER	
NAME:	
ADDRESS	
CITY/STATE/ZIP:	
PHONE:	FAX:

INFORMATION TO BE RELEASED:

___ Initial Evaluation ___Discharge Summary ___Medication Information
___ Lab Reports ___Progress Notes ___Appointment Attendance
___ Other (specify) _____

I understand, upon my request, I may receive a copy of this release and that the information released may be mental health or substance abuse related. I also understand there may be a charge, payable in advance, for the copying and conveyance of records released. I further understand the above consents can be withdrawn by me, in writing, at any time. I cannot, however, hold exception to actions that have taken place before I withdrew my consent. This consent expires one year from the signature date.

_____ _____

Signature of Client or Responsible Party Date

HIPPA PATIENT COMMUNICATION FORM

NAME: _____ **DOB:** _____

As a patient in our practice, from time to time we may need to communicate with you when you are not in the office. To preserve your privacy, we would like for you to indicate your preferred method for us to communicate medical information to you, and to others involved in your care, if needed.
Examples of medical information include appointment reminders and nutrition plan information.

Without specific permission we will not release any of your medical/nutrition information to another person. In some cases you may wish for another person to have access to your medical information. Please identify those individual(s) and their relationship to you (i.e. spouse, parent, son, daughter, etc)

NAME: _____ **RELATIONSHIP:** _____

NAME: _____ **RELATIONSHIP:** _____

WOULD YOU LIKE AN APPOINTMENT REMINDER?

In the event that no one is available to answer your phone, we need permission to leave certain types of information on your answering machine/voicemail. Please indicate your preference by checking one of the spaces below:

- ☐ Do not leave any medical information on my answering machine or voice mail. In this event you will only be asked for a return call to receive further information.
- ☐ I give Eat Well with Gina personnel permission to leave medical Information pertaining to me on my answering machine or voice mail at the number(s) listed below:

PREFERENCE: □ **Email** □ **Home Ph** □ **Cell Ph** □ **Text** □ **None**

I assume responsibility to inform Eat Well with Gina, LLC of changes in my phone number(s) or my preference for information release. I also acknowledge that I have received and/or read a copy of Eat Well with Gina's privacy practices.

NAME: _____

SIGNATURE: _____ **DATE:** _____