RESTORED WELLNESS
NUTRITION

Authorization of release/disclosure of protected information

I authorize Katie Burford, NTP to release/disclose my protected information to the following providers:
Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

This authorization for release of information covers all past, present and future appointments.

This authorization shall be in force and effect until the end of treatment with Katie Burford, NTP at which time this authorization expires.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted on my authorization.

Name of client (printed): _____ Date: _____

Signature of client: _____

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