Authorization to Obtain/Release Confidential Information

Client's name:_____ Date of birth:_____
Client's address:_____
Phone number:_____
I authorize Erica Van Mieghem MS, RD, CD, CN to share/retrieve my treatment progress and health care information/medical records with professional consultants and the following individuals:

Physician (please print clearly)
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
E-mail:_____

Naturopath (please print clearly)
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
E-mail:_____

Psychiatrist (please print clearly)
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
E-mail:_____

Other (please print clearly)
Name: _____
Address: _____
_____
Phone: _____
Fax: _____
E-mail:_____

I understand that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein.

Date: _____ Client Signature: _____

Parent/Guardian* Signature: _____
*If client is under the age of 18 parent or guardian must provide signature