Be Well. Morristown

Authorization to Obtain and Release Confidential Information for the Purpose of Assessment and Future Treatment

I, _____ (**Client name, Parent or Guardian**), hereby authorize New Jersey Center for Nutrition and Dietetics, LLC., to obtain and release information regarding past and current treatment for _____ (**Client name**) to and from the following listed below. This information may include full health history, general and specific information regarding medical and psychological assessment/treatment and progress notes, laboratory test, growth charts, special evaluations/testing, nutrition evaluation and counseling, school performance, social and emotional functioning, special learning problems or capabilities, educational testing, etc.

Please provide the contact information for your <u>current and/or past therapist, physician, psychiatrist, nutritionist, treatment center, coach, school/university, personal and family members</u> with who you chose to have New Jersey Center for Nutrition and Dietetics, LLC., communicate with as part of your treatment.

_____	_____
***Name/Title** **Relationship**	***Name/Title** **Relationship**
_____	_____
Address	Address
_____	_____
City Zip code	City Zip Code
_____	_____
Phone Number Fax Number	Phone number Fax Number
_____	_____
Email/Website	Email/Website
_____	_____
***Name/Title** **Relationship**	***Name/Title** **Relationship**
_____	_____
Address	Address
_____	_____
City Zip code	City Zip Code
_____	_____
Phone Number Fax Number	Phone number Fax Number
_____	_____
Email/Website	Email/Website

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

_____	_____
Client Signature	**Date**
_____	_____
Parent/Guardian signature	**Date**