Client Name: _____ Date of Birth: _____/_____/_____

I hereby allow communication and release of records between Pam Chin-Lai, RD, LD, CEDRD and the following providers, guardians and other people as needed:

❑ Girls to Women Health and Wellness and Young Men's Health and Wellness

Physician's Name: _____ Phone: _____

Psychiatrist's Name: _____ Phone: _____

Therapist Name(s): _____ Phone: _____

Guardian(s): _____ Phone: _____

Other: _____ Phone: _____

Other: _____ Phone: _____

Information to be disclosed. If all health information is to be released, then check only the first box.

- ☐ ALL Health Information: including Medical Summary, Growth Charts, Lab Reports
- ☐ Growth Charts
- ☐ Lab/Testing Reports
- ☐ Mental Health Records
- ☐ Other (please specify): _____

Client's Initials are required to release the following information:

____ Mental Health Records
____ Drug, Alcohol or Substance Abuse Records
____ Genetic Information (including Genetic Test Results)
____ HIV/AIDS Test Results/Treatment

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and the information given above is accurate and complete to the best of my knowledge. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation will be effective upon receipt by Pam Chin-Lai, RD,LD, CEDRD. I have read and understand the terms of this Authorization, and hereby knowingly and voluntarily Pam Chin-Lai, RD,LD, CEDRD to use or disclose my health information in the manner described above. This authorization expires upon my written request.

Client's Signature (18 years of age and older): X_____ _____/_____/_____
Client Signature (Adult clients only) Date

Minor's Signature

A minor individual's signature is required for the release of certain types of information , including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment.

X_____ _____/_____/_____
Client Signature (minor clients only) Date

Parent/Guardian's Signature Specify relationship to patient ☐ Parent of Minor ☐ Guardian ☐ Other: _____

X _____ X_____ _____/_____/_____
Parent/Guardian (print) (if client is a minor) Parent/Guardian Signature (if client is a minor) Date