Lifestyle Change and
Nutritional Counseling
Marriage, Family and
Individual Counseling

PO Box 151373
San Rafael, CA 94915
kia@kailocounseling.com
415.813.6183

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date: ______________________

To: ___________________________________
____

Dear ___________________________________

I hereby authorize and request that you release and *please (check one)*
☐ *FAX,* ☐ *Email,* ☐ *Priority Mail,* ☐ *FedEx or* ☐ *UPS overnight* to:

Kia Sanford MS CN
Counseling and Clinical Nutrition
PO Box 151373
San Rafael, CA 94915
415-813-6183 (phone)
kia@kailocounseling.com (secure/confidential email)
877-565-7363 (secure/confidential toll-free fax)

☐ Most recent; ☐ For the period of _____ to _____; ☐ All
medical records, charts, files, prognoses, reports, x-ray or scan reports, laboratory reports, clinical records, and such other information relative to my medical condition or my treatment at any time provided to me and to the extent said information is available and within your possession. You may bill me for any costs. You are further requested not to disclose any information concerning my past or present medical condition to any other person, unless it is specific to my medical care or treatment as per HIPAA, without my express written permission.

Thank you for your assistance.

Name ____
Social Security or Patient Number ___________________
Address____
____
Phone ____
Birthday ____

Signature ____