Whole-istic Living, LLC
10 Cedar Street, Suite 24
Woburn, MA 01801
781-864-4285
www.WholeisticLivingLLC.com

AUTHORIZATION FOR RELEASE OF INFORMATION

I, ___________________________, authorize healthcare providers at Whole-istic Living to discuss nutritionally pertinent information about my treatment progress to:

1. ____
   Physician **Phone**
   ____
   Address, City, State, Zip **Fax**
2. ____
   Psychiatrist **Phone**
   ____
   Address, City, State, Zip **Fax**
3. ____
   Primary Therapist **Phone**
   ____
   Address, City, State, Zip **Fax**
4. ____
   Other **Phone**
   ____
   Address, City, State, Zip **Fax**
5. ____
   Other **Phone**
   ____
   Address, City, State, Zip **Fax**

With regard to/concerning: ____
(Client's first and last name - printed)

I understand that my records and treatment are confidential and will not be disclosed without my written consent.

______________________________________ ______________________
Signature of Client Date

______________________________________ ______________________
Signature of Parent/guardian (if Client is a Minor) Date

I have received Whole-istic Living's HIPPA Privacy Notice:

______________________________________ ______________________
Signature of Client Date

______________________________________ ______________________
Signature of Parent (if Client is a Minor) Date