SOUND DIETITIANS

PO BOX 5115
LYNNWOOD, WA 98046

PHONE: 425-409-3544
FAX: 425-354-3544

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Name of Patient:	
Address:	
Phone Number:	E-mail:
Birthdate:	Other Aliases/Names:

Name of Guardian or Legal Representative (if needed):	
Address:	
Phone Number:	E-mail:

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, consumer reporting agency, employer or family member to release all health information about me to Sound Dietitians.

Signature:	Date:

Person/Organization to Release Information:		
Street Address:		
City:	State:	Zip:
Phone Number:		Fax: