

KAILO COUNSELING

LIFESTYLE CHANGE AND
NUTRITIONAL COUNSELING
MARRIAGE, FAMILY AND
INDIVIDUAL COUNSELING



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KIA SANFORD MS CN

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Date: _____

To: _____

Dear _____

I hereby authorize and request that you release and *please fax, Priority Mail, FedEx or UPS overnight* to:

Kia Sanford MS CN
Counseling & Clinical Nutrition
PO Box 151373
San Rafael, CA 94915
877-565-7363 (toll free fax)

my most recent and pertinent 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 _____ Birthday _____

Social Security or Patient Number _____ Phone _____

Address _____

Signature _____