



*Christina Scribner MS RD CSSD CEDRD, Nutrition Consultant,
Encompass Nutrition LLC*

Authorization for Release of Information

~Completion of this form is optional~

Send the completed form or any changes to:

Christina Scribner MS RDN CSSD CEDRD
8119 Shaffer Parkway, STE 104
Littleton, CO 80127
Phone: 303 949 1177
Fax: 303 933 8882

What happens if I don't complete this form?

You are asked to complete the following form to allow for continuity of care with other health care providers and for insurance purposes. If this form is not signed or current, I will continue to protect your private health information.

What if I change my mind?

You can change or revoke this process at any time by writing to me at the address above.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If someone is helping with billing or payment
- If a friend is helping or family member is helping with health issues
- If a college student wants information shared with a parent
- If an adult child or parent of teenager calls to find out a patient's appointment time

How is the information on the form used?

Anytime your designated person calls or makes a request on your behalf, I will verify the individual has your permission to receive the information and then I will share the information. Complete the Release of Information form on the reverse side of the next page to let me know to whom I may speak about your information. Check the appropriate boxes to indicate what information I may discuss. You may also send me a letter with this information.

How can I give others permission to get verbal information about me?

I have established a process that allows you to tell me who I may talk with about your care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

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Name: _____ **Date of Birth:** _____ **Age:** _____

Address: _____

Home Phone: _____ **Work/Cell Phone:** _____

I give permission to Christina Scribner to release to / and or receive information from my clinical//medical file to facilitate continuity of care and treatment. Examples of information shared between health care providers may include, but is not limited to:

- Scheduling and appointment information
- Medical information, including my symptoms, diagnosis, medications, treatment plan
- Behavioral information, including my symptoms, diagnosis, medications, treatment plan
- Chemical use, dependence, and abuse information including my symptoms, diagnosis, treatment plan
- Lab and other medical tests/results
- Billing and payment information

I authorize Christina Scribner, Encompass Nutrition LLC, to release any medical or incidental information that may be necessary for processing application for financial benefit. I authorize direct payment of medical benefits by my insurance carrier and any information needed to determine these benefits or related services. I understand that I am financially responsible for paying the balance of service not covered by insurance.

Consider listing parents, health care providers, counselors, coaches below:

1. Name _____ Relationship _____
 Work/Office phone: _____ Ext: _____ Fax: _____
 Street address _____ City, State, Zip: _____

2. Name _____ Relationship _____
 Work/Office phone: _____ Ext: _____ Fax: _____
 Street address _____ City, State, Zip: _____

3. Name _____ Relationship _____
 Work/Office phone: _____ Ext: _____ Fax: _____
 Street address _____ City, State, Zip: _____

4. Name _____ Relationship _____
 Work/Office phone: _____ Ext: _____ Fax: _____
 Street address _____ City, State, Zip: _____

I understand that this authorization will be valid for 360 days after I discontinue treatment and will allow sharing of any records shared up to this date and to the date this authorization expires. I understand that I have the right to revoke my permission at any time except where Christina Scribner has already made disclosures in reliance upon this request, that I may cancel this authorization by sending written notice to Christina Scribner, and that the cancellation will take effect when my notice is received by Christina Scribner.

Patient: _____ **Date:** _____

Parent/Guardian (if under 18 years old) _____ **Date:** _____

Parent/Guardian name: _____ Work ph: _____ Home/Cell ph: _____

Street address: _____

City, State, Zip: _____