~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

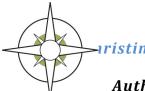
How is the information on the form used?

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.

—Completion of this form is optional—



-iristina Scribner MS RD CSSD CEDRD, Nutrition Consultant, Encompass Nutrition LLC

Authorization for Release of Information

~Completion of this form is optional ~

Name:		D	ate of Birth:_	Age:
Address:				
Home Phone:				
	tina Scribner to release to / and re and treatment. Examples of i to:		-	
Medical informaBehavioral informaChemical use, de	appointment information tion, including my symptoms, di mation, including my symptoms, ependence, and abuse information edical tests/results ent information	, diagnosis, medi	cations, treatme	nt plan
be necessary for procession insurance carrier and any	ner, Encompass Nutrition LLC, to ng application for financial bene information needed to determi e for paying the balance of service	fit. I authorize d ne these benefit	lirect payment or s or related serv	f medical benefits by my
Consider listing parents	s, health care providers, coun	selors, coaches	s below:	
1. Name		Relationship		
Street address				
2. Name		Relationship		
			Zip:	
3. Name		Relationship		
			Zip:	
4. Name		Relationship		
Work/Office phone:			Fax:	
records shared up to this da permission at any time exce	orization will be valid for 360 days a te and to the date this authorization or where Christina Scribner has also on by sending written notice to Chr ristina Scribner.	on expires. I unde ready made disclo	rstand that I have sures in reliance u	the right to revoke my pon this request, that I
Patient:				Date:
Parent/Guardian (if und	der 18 years old):		- <u></u>	Date:
Parent/Guardian name	:	Work ph	:	Home/Cell ph:
Street address:				