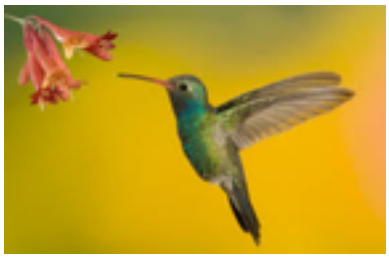

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Finding Freedom Nutrition, LLC

I, _____ (name), DOB: _____ authorize Aisha Kashif Lubinski of Finding Freedom Nutrition, LLC to release/obtain information to/from

Name:
Address:
Work Phone:

In regard to services provided to me during treatment. This disclosure will be made for the following purpose: Coordination of Care

Specific Information to be provided is to consist of the following:

I AGREE to release a narrative account of case history, course of treatment, prognosis, social history and discharge recommendations.

I AGREE to release a copy of my records including case history, course of treatment, prognosis and recommendations for ongoing treatment.

I AGREE to release information for the purpose of collaborative care and relation development between Finding Freedom Nutrition, LLC and my care provider.

READ CAREFULLY: I understand that my medical/health information records are confidential. I understand that by signing this authorization, I am allowing the release of my medical/health information. The protected health information (PHI) in my medical record includes mental.behavioral health information.

This authorization includes information presently compiled and information to be compiled during the course of treatment.

The authorization becomes effective on _____ (date). The authorization automatically expires 1 year from the above date.

I understand that I have the right to receive a copy of this authorization. A photographic copy of this authorization is as valid as the original.

I understand that authorizing the disclosure of this medical/health information is voluntary. I can refuse to sign this authorization.

My signature below acknowledges that I have read, understand, and authorize the release of my PHI.

Signature: _____