Authorization to Release and Exchange Information

I hereby authorize: Ursula Ridens, RD Inc.
Ursula Ridens, RDN, CEDRD
(619) 993-7895 Fax (619) 369-4566

to release and/or exchange information regarding diagnosis, treatment, and prognosis for:
(X) Physical injuries, illnesses, and conditions
(X) Psychological or psychiatric illnesses or conditions
(X) Alcohol or other drug-related conditions

regarding: X_____ X_____
(Client Name) (Date of Birth)

to/with: X_____
(Name)

X_____
(Address) (City, State, Zip)

X_____ X_____
(Phone) (Fax)

This information is required for: (X) Coordination of care
or ( ) _____
and is limited to: (X) Relevant clinical information
or ( ) _____

Please forward medical records (X) Yes ( ) No

X_____
(Print Client Name)

X_____ X_____
(Client's Signature) (Date)

X_____ X_____
(Parent or Legal Guardian's Signature if Client is Minor) (Date)

Renewed: _____ _____
(Client's Signature) (Date)

Renewed: _____ _____
(Client's Signature) (Date)