CONSENT FOR RELEASE OF MEDICAL INFORMATION

Appropriate treatment requires the efforts of a multidisciplinary team that works together closely and shares pertinent information. Confidential information will be provided only to the parties identified below. Jennifer (Jenna) Hollenstein will not disclose confidential information to any other party unless required by law. Please see HIPAA Notice of Privacy Practices for more information.

I, _____, with date of birth _____, voluntarily authorize the following person(s) to release medical information to Jennifer (Jenna) Hollenstein, MS, RDN, CDN.

Name:

_____

Address:

_____

_____

Phone:

_____

Email:

_____

Name:

_____

Address:

_____

_____

Phone:

_____

Email:

_____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

Name:

_____

Address:

_____

_____

Phone:

_____

Email:

_____

Information is to be released to:

Jennifer (Jenna) Hollenstein, MS, RDN, CDN
62 Country Road
Mamaroneck, NY 10543

Client/Guardian Signature: _____Date: _____