CAROLYN M. FELTON, MPH, RDN/LDN, CEDRD • Nutrition Therapy
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AUTHORIZATION TO OBTAIN/RELEASE CONFIDENTIAL INFORMATION

Client name:_____ Date of Birth:_____

I, _____ authorize
(Client or Parent/Guardian if client under age 18)

Carolyn M. Felton, MPH, RDN, LDN to:
❑ discuss treatment progress;
❑ obtain medical records and/or progress notes; and/or
❑ release medical records and/or progress notes

for myself/my child with the following individual(s):

Physician:_____

Address:_____

Phone:_____ Fax:_____

Therapist:_____

Address:_____

Phone:_____ Fax:_____

Other:_____

Address:_____

Phone:_____ Fax:_____

Other:_____

Address:_____

Phone:_____ Fax:_____

I understand that medical records and treatment are confidential and will not be disclosed without my written consent. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein.

Signature:_____ Date:_____