HIPAA AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION TO PHYSICIAN

I, _____ (client name) hereby authorize Ideal Body Myrtle Beach, LLC to release and disclose my health and weight loss information to the named physician(s) below for the purposes of collaborative advocacy on my behalf. Method of release shall be pertinent to the need, and may include photocopies, postal mail, computer files, email, telephone, and electronic or verbal communication.

Dr._____

Address_____

_____

City_____

State_____Zip_____

Phone_____ Fax _____

Specialty_____

Dr._____

Address_____

_____

City_____

State_____Zip_____

Phone_____ Fax _____

Specialty_____

Dr._____

Address_____

_____

City_____

State_____Zip_____

Phone_____ Fax _____

Specialty_____

Client Signature_____

Date_____