Kerri Schwartz, MS, RD
2211 Corinth Avenue Suite 307
Los Angeles, California 90064
310.312.4888

AUTHORIZATION TO OBTAIN or RELEASE CONFIDENTIAL INFORMATION

I authorize Kerri Schwartz, MS, RD to

* Discuss my treatment progress with
* Obtain medical records or progress notes from
* Release medical records or progress notes to

the following individuals:

__ Primary Therapist __ Dietitian __ Physician __ Psychiatrist __ Other

Name _____
Address _____
_____
Phone _____

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

I hereby agree to the terms of this consent.

Date: _____ Client Signature: _____

Parent/ Guardian Signature: _____

I revoke my consent:

Date: _____________ Signature: ____