Elizabeth Smoots, Certified Health & Wellness Coach
www.drsmoots.com/healthcoach

Authorization for the Release of Information

I, the undersigned Client, herby authorize Elizabeth Smoots to release and/or disclose my health information to any health care provider to whom I am being referred for care. I also authorize Elizabeth Smoots to release and/or disclose my health information to the Health Care Providers named below.

Health Care Provider

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone_____ Fax Number_____

Health Care Provider

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone_____ Fax Number_____

Health Care Provider

Name_____

Address_____

City_____ State_____ Zip Code_____

Phone_____ Fax Number_____

Duration: This authorization shall become effective immediately upon the date of signature and shall remain in effect until _____; if no date is entered, there is no time limit.

Revocation: This authorization may be revoked in writing by the undersigned at any time upon notice to Elizabeth Smoots. Written revocation will not affect any action taken in reliance of this authorization before the written revocation was received.

Check the box for which type of information is to be released and/or disclosed.

____All health information; this is the default if no other option is chosen.

____All health information with the following exceptions_____

____Only the information specified as follows_____

Client Name (printed)_____

Signature of Client_____ **Date**_____