Consent for Release of Medical Information

Appropriate treatment requires the work of a multidisciplinary team that works closely together and shares pertinent information. Confidential information will be provided only to the parties identified below. Theresa Kinsella 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 the following date of birth ______________ voluntarily authorize the following person(s) to release medical information to Theresa Kinsella MS, RD.

Name: ____

Address: ____

____

Phone: ____

Name: ____

Address: ____

____

Phone: ____

Name: ____

Address: ____

____

Phone: ____

Information is to be released to:

Theresa Kinsella MS, RD

280 Madison Avenue, Suite 1004, New York, NY 10016

646.351.9148

Client's Signature: ____ **Date:** _______________

Theresa C Kinsella MS, RD, CDN
280 Madison Avenue, Suite 1004
New York, New York 10016
theresakinsellard@gmail.com
646.351.9148