nutrition in motion

A CLEAR PATH TO A HEALTHY LIFESTYLE

AUTHORIZATION TO RELEASE PERSONAL HEALTH INFORMATION

By signing this document, I knowingly and willingly agree to have my personal health information, obtained by Nutrition in Motion, LLC, shared with [name of person and/or organization, address, and fax number] – Please print.

_____

_____

This information will be shared in writing and/or verbally for the stated purpose(s) of _____

_____

_____

_____

_____

The party to whom the information is shared will be subject to the Health Insurance Portability and Accountability Act of 1996.

This authorization shall remain in force until such time as I notify Nutrition in Motion, LLC of my desire to revoke it and I understand that I have the right to do so at any time. The request for revocation must be in writing and hand-delivered to Nutrition in Motion.

Participant's Name [Print]:_____

Participant's Signature:_____

Participant's Date of Birth:_____

Date: _____