



TOTAL HEALTH CONCEPTS, LLC
(703) 255-7012 / FAX (703) 255-6171

Nutrition, Fitness and Behavioral Counseling Services

Authorization for Exchange of Information

I grant authorization for an exchange of professional, confidential information between
_____ of Total Health Concepts, LLC and

(Therapist / Dietitian)

Therapist

Physician

Dietitian

Insurance carrier

Name: _____

Address: _____

Phone Numbers: _____

In Regard to:

Myself: Name _____ Date of Birth _____

My child: Name _____ Date of Birth _____

The purpose for this exchange of information is to:

Discuss treatment progress

Obtain medical records and/or progress notes

Release medical records and/or progress notes

Exchange of information is to be:

On-going

One time only

Expiration date for this authorization: _____

This authorization is signed with the understanding that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. Further, it is understood that I may withdraw this authorization in writing any time prior to the expiration date.

Date: _____

Client Signature: _____

Parent/Guardian Signature: _____

Therapist/Dietitian Signature: _____