Kay S Beatty, MS, RDN
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Permission to Coordinate with Another Healthcare Provider

Patient's name ____ Birthday ________________________

Patient's address ____

____ Patient's phone # ___________________________________

Patient's email address ____

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Name of Healthcare Provider ____

Provider's Address ____

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Phone # _____________________________________ Fax # _______________________________________

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My dietitian, Kay S Beatty MS RDN, may wish to exchange pertinent information about my current treatment with the healthcare provider listed above. I hereby authorize the use or disclosure of my individually identifiable health information with the healthcare provider listed above. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time.

Patient's signature ____ Date ___________________

Patient's name, printed ____ Date ___________________

Representative's signature (if applicable) _________________________________ Date ___________________

Representative's name, printed (if applicable) ____________________________ Date___________________