Delicious NUTRITIOUS
NUTRITION THERAPY FOR VIBRANT HEALTH

RECORDS RELEASE AUTHORIZATION

To:_____
Doctor/Hospital

Address: _____

Office Phone: _____ Fax: _____

I hereby authorize and request you release to:

Catherine Layden, MNT
400 E 3rd Ave #1001, Denver, CO 80203
Phone: (303) 722-7698
Fax: (720) 528-8197
info@deliciousnutritioushealth.com
www.deliciousnutritioushealth.com

The following information:
_____ Lab Only
_____ Complete Medical Records

I authorize the release of photocopies of the following medical records or files. Records or files shall include all confidential and communicable disease-related information (as defined in ARS 36-661), confidential alcohol or drug abuse related information and confidential mental health diagnosis/treatment information. I authorize release of records concerning my illnesses and/or treatments from _____ to _____.

Name: _____ DOB: _____

Address: _____

Signature: _____ Date: _____