

SOUTHEAST CLINICAL NUTRITION CENTERS, INC.  
1462 Montreal Road, Suite 203 | Tucker, GA 30084 | (678) 527-0800, (770) 674-1871 Fax

Consent for Release of Medical Records

FROM: Patient Name \_\_\_\_\_  
Patient Address \_\_\_\_\_  
Patient Birth Date \_\_\_\_\_  
Patient Social Security Number \_\_\_\_\_

TO: Angelo P. Capozzoli, RD, CSR, LD  
Southeast Clinical Nutrition Centers, Inc.  
1462 Montreal Road  
Suite 203  
Tucker, GA 30084

I do hereby consent and authorize you to release copies of my medical records, including current and previous medical records from other practices and practitioners, hospitals, and/or clinics which are a part of my medical records. PLEASE NOTE: This authorization includes consent for the release of alcohol, drug, psychiatric and psychological information; and any information relating to pregnancy, sexually transmitted diseases, HIV Testing, AIDS, and any AIDS-Related Syndromes. It also includes any information concerning Cancer, Cancer Testing, and Cancer Results. I agree that a copy of this release or a fax of this release shall be as valid as the original release. Please send copies of all required information as soon as possible to the address listed below:

\_\_\_\_\_ SEND ALL MY RECORDS

\_\_\_\_\_ SEND RECORDS FROM (DATE) \_\_\_\_\_ TO (DATE) \_\_\_\_\_

SEND RECORDS TO:

Angelo P. Capozzoli, RD, CSR, LD  
Southeast Clinical Nutrition Centers, Inc.  
1462 Montreal Road  
Suite 203  
Tucker, GA 30084

\_\_\_\_\_  
Patient Signature or Mark Date

\_\_\_\_\_  
Witness Signature Date