**AUTHORIZATION FOR RELEASE OF INFORMATION FORM**

TO WHOM IT MAY CONCERN:

I DO HEREBY AUTHORIZE you to release a copy of my entire chart, including, but not limited to, all x-rays, hospital records, medical records, progress notes, reports on diagnostic tests, medical opinions and/or any other knowledge or information which you may possess, to the New Brunswick Association of Dietitians, c/o the Registrar, and for so doing, let this be your good and sufficient authority.

I DO HEREBY AUTHORIZE the New Brunswick Association of Dietitians to disclose the information and records obtained under this authorization to the Dietitian(s) or Dietetic Intern(s) named in the complaint in order to allow the Dietitian(s) or Dietetic Intern(s) to respond to the complaint.

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Print Complainant’s Full Name

Complainant’s Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Complainant’s Medicare Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature of Complainant Date

The New Brunswick Association of Dietitians investigates all complaints. In order for a third party to receive specific information regarding a complaint, including a Dietitian’s reply to the letter of complaint, the Association requires photocopies of documentation specifying that the third party has Power of Attorney for the patient, legal guardianship of the patient, or is an Executor of the patient’s Estate.

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| Office Information Only (Complainant do not complete)  Date received in Office: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  File Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |