

Ann M. Del Tredici, MS, RD, CDE
Registered Dietitian, Certified Diabetes Educator
929 Sir Francis Drake Blvd, Suite 102
Kentfield, CA 94904
Telephone and Fax: 415-256-1301
anndt@aol.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Full
Name: _____

Date of Birth: _____

I request and authorize **Ann M. Del Tredici, MS, RD, CDE** to
release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

☐ All healthcare information

☐ Other: _____

☐ Yes ☐ No

I authorize the release of any records regarding mental health treatment to the person(s) listed
above.

Patient/Parent
Signature: _____

Date Signed: _____

THIS AUTHORIZATION EXPIRES 180 DAYS AFTER IT IS SIGNED.