Authorization For Release of Information

Client Name:_____ Date of Birth:_____

Client Address:_____

City, State, Zip:_____ Client Phone Number:_____

I,_____ authorize Jessica Germanese, RD, LD
(name of client/guardian)

to _____obtain information, and/or _____release information, as specified to the following (please √)

person(s):

Name:_____

Address:_____

_____

Telephone #:_____

Fax #:_____

Purpose of this Request:_____

Specific Information Authorized:
□ Lab Values/Medical Test Results □ Medical Records □ Dietary Information

□ Other:_____

Signed:_____ Date:_____
(Signature of client or guardian)

Witness:_____ Date:_____