Release of Information

From health Care Provider to NutritionRx

Name: _____

Health Care Provider, Signature:_____
Title_____

I,_____(Patient/Legal Guardian)
authorize the above listed health care provider to release any information related to the development, implementation, and evaluation of my individual treatment plan, and to the payment of claims for services to NutritionRx.

Information Needed:

_____
_____
_____
_____

I understand that I should retain a copy of this signed release form and that a photocopy of this form is as valid as the original.

Signature: _____ Date: _____

Nutrition & Diet Counseling Associates
1309 Beacon Street, Floor 3 Brookline, MA 02446