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Consent for Release of Information

When you complete and sign this form, it allows your nutritionist/ dietitian to communicate with the person/persons you designate about your nutritional situation and care.

I authorize Susan D. Engle, MOE, RD, LD to communicate with

_____ (physician or PCP)

_____ (counselor/therapist)

_____ (other health professional – please specify type)

This authorization shall remain in effect for 1 year from the date it is originally signed.

You have the right to revoke this authorization, verbally or in writing, at any time by telephoning, e-mailing, or writing to me.

Signature _____

Date _____