Authorization to Release Confidential Records/Information

Client:

Phone Numbers:

Address:

Work:

Cell:

Email:

Other:

I authorize Registered Dietitians from Fruition Nutrition, LLC to release records and/or information to and to receive records/information from the following individuals.

	Name:	Address:	Phone:
Therapist/Counselor:			
Psychiatrist:			
Physician:			
Parent/Guardian:			
Other/Specify:			

☐ I give permission for Fruition Nutrition, LLC to discuss my case via email and text using my initials. I give permission to email and text appointment/scheduling related correspondences.

I understand this request for information to release my records and information.

_____	_____	_____
Signature	Printed Name	Date

_____	_____	_____
Signature of Parent/Guardian	Printed Name	Date