

RELEASE OF INFORMATION

(From Health Care Provider to Marci RD Nutrition Consulting)

Name: _____

Health Care Provider:

Signature/Title _____

I, _____ (Patient/Legal Guardian) do hereby 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 Marci RD Nutrition Consulting, LLC.

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: _____

