Cheryl Craig, RD

626-255-2576
cherrd@aol.com • www.cherrd.com

Authorization for Release of Information

I authorize Cheryl Craig, RD to discuss (verbally or in writing) anything that has been brought up during our nutrition counseling sessions with any person(s) or staff of clinic, office, agency, or institution named below and receive any relevant information from them.

Name:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

Name:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

Name:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

Name:_____

Address:_____

Phone:_____ Fax:_____

Email:_____

I may revoke this consent at any time. This consent is in effect only for five years from the date of the last session, unless revoked in writing earlier or renewed.

Name: (print)_____

Name: (signature)_____ Date:_____

Dietitian: (print)_____

Dietitian: (signature)_____ Date:_____