Branz Nutrition Counseling, LLC

Erica L. Branz MS, RD, LDN, CEDRD | Alexis Hughes, RD, LDN | Michelle Wilson MS, RD, LDN

24 South Gore 787 Sunset Blvd

Webster Groves, MO 63119 O’fallon, IL 62269

Authorizations to Release/Consent of Information

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client’s Name Date of Birth

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address City/State/Zip Phone #

I authorize the dietitians of Branz Nutrition Counseling to obtain and release my treatment progress and health care information/records to the listed health care providers and the following individuals.

Primary Therapist

Name:

Address:

Phone:

Fax:

Email:

This permits the release/consent of the following information:

\_\_\_\_ Diagnosis

\_\_\_\_ Treatment Plan

\_\_\_\_ Progress to Date

\_\_\_\_ Prognosis

\_\_\_\_ Clinical Test Results

\_\_\_\_ Dates of Treatment

\_\_\_\_ Any and All Information Necessary

\_\_\_\_ Other (specify)

Psychiatrist:

Name:

Address:

Phone:

Fax:

Email:

This permits the release/consent of the following information:

\_\_\_\_ Diagnosis

\_\_\_\_ Treatment Plan

\_\_\_\_ Progress to Date

\_\_\_\_ Prognosis

\_\_\_\_ Clinical Test Results

\_\_\_\_ Dates of Treatment

\_\_\_\_ Any and All Information Necessary

\_\_\_\_ Other (specify)

Parents/Spouses/Siblings/etc.

Name:

Address:

Phone:

Fax:

Email:

This permits the release/consent of the following information:

\_\_\_\_ Diagnosis

\_\_\_\_ Treatment Plan

\_\_\_\_ Progress to Date

\_\_\_\_ Prognosis

\_\_\_\_ Clinical Test Results

\_\_\_\_ Dates of Treatment

\_\_\_\_ Any and All Information Necessary

\_\_\_\_ Other (specify)

Other:

Name:

Address:

Phone:

Fax:

Email:

This permits the release/consent of the following information:

\_\_\_\_ Diagnosis

\_\_\_\_ Treatment Plan

\_\_\_\_ Progress to Date

\_\_\_\_ Prognosis

\_\_\_\_ Clinical Test Results

\_\_\_\_ Dates of Treatment

\_\_\_\_ Any and All Information Necessary

\_\_\_\_ Other (specify)

This authorization will not expire unless expiration date is noted: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature Date Parent/Guardian Signature Date