Branz Nutrition Counseling, LLC

Erica L. Branz MS, RD, LD, CEDRD | Alexis Hughes, RD, LD | Erin Bushman RD, LD, CEDRD

5 Plant Ave; Suite 2 4972 Benchmark Centre Drive; Suite 100

Webster Groves, MO 63119 Swansea, IL 62226

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