Consent to Release Confidential Information

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I give permission for Deborah McCarthy RD, CPT, CBCC to consult with and share confidential information with the following medical/clinical practitioners:

Name _____

Address _____

Phone number _____

Name _____

Address _____

Phone number _____

Name _____

Address _____

Phone number _____

This release will be valid for 12 months from the signature date. This information is being released for the following reason:

_____

_____

_____ _____

Patient name (printed) Patient signature (if minor, parent signature)

Address _____

Phone number _____

Date signed _____