MEDICAL RELEASE AUTHORIZATION FROM WEBNUTRI CLINIC

I hereby authorize Shefali Ajmera, MS, RD, LD at Webnutri clinic to release my nutrition information/reports or billing records to following person/entity

Name of requesting party: _____

Requesting party address or fax: _____

Reason for release: _____

Signature (this document must be signed by the individual, parent of minor child or the individual's personal representative):

Signature of Patient / Patient's Personal Representative**

_____ Date Signed: _____

Relationship if not Patient: _____

Printed Name: _____ Date of birth: _____

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