NourishMentor
Nutrition Coaching For Peaceful Eating

NourishMentor, LLC
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Authorization for Release and Exchange of Information for NourishMentor, LLC

Name of Client:	
Address:	
Phone number:	Email:
Birthdate:	
Name of Guardian or Legal Representative (if needed):	
Address:	
Phone number:	Email:
Person/Organization to Release/Exchange Information:	
Address:	
Phone number:	Fax:
Person/Organization to Release/Exchange Information:	
Address:	
Phone number:	Fax:
Person/Organization to Release/Exchange Information:	
Address:	
Phone number:	Fax:

I hereby authorize the above health care professional, medical facility, mental health facility, laboratory, paramedical facility, medical examiner, medical records service, prescription history clearinghouse, consumer reporting agency, employer or family member to release and/or receive all health information about me to or from NourishMentor, LLC via secure written or verbal communication for the purpose of coordination of care.
I know that I may cancel this release of information at any time, without any reason.

Signature: Date:

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