Sage Nutrition
NOURISH | MOVE | EMPOWER

Release of Health Information Consent Form

I, _____ authorize Sage Nutrition, LLC to :
_____(send) _____(receive) the following information checked below (to)_____
(from)_____ the following agencies or professionals:

Name	Address	City	NE	Phone
Name	Address	City	NE	Phone
Name	Address	City	NE	Phone

□ Entire Clinical Record
□ Meal Plan
□ Two-way Communication
□ Vitals Review
□ Nutrition Assessment
□ Other (specify) _____

The above information will be used for the following purpose:

□ Planning appropriate treatment program or follow-up care
□ Case Review
□ Updating Files
□ Determining eligibility for benefits for programs

I understand that I may revoke this consent at any time by providing written notice, and after one year this consent will automatically expire. Listed above is the information that will be given, its purpose, and who will receive the information. I understand and agree with the Release of Health Information Consent Form.

Signature of Client or Guardian: _____ Date: _____