COASTAL
FAMILY NUTRITION

Consent to Send Information

Today's date: _____

Patient's name_____ Date of Birth_____

Address_____

Phone_____

I request and authorize:

Karen Mountjoy MEd, RD, LD, CLC
Coastal Family Nutrition
230 Lafayette Road, Suite 13A
Portsmouth, NH 03801
Fax: 603-590-7471

to release healthcare information of the person named above to:

_____

_____

This request and authorization applies to:

[ ] healthcare information regarding the following treatment, condition or dates:

_____

_____

_____

[ ] other:_____

Signature:_____ Date_____