



Consent to Exchange Information

Today's date _____

Patient's name _____ Date of Birth _____

Parent/Guardian name _____

Address _____

Phone _____

I request and authorize:

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

to exchange healthcare information of the person named above with:

This request and authorization applies to:

healthcare information regarding the following treatment, condition or dates:

other: _____

Signature: _____ Date _____