STERLING NUTRITION

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Consent to Release Information

PATIENT'S NAME: DOB:

I, _____(patient's name or parent's name if minor) consent to release information regarding the nutrition care of _____ (patient's name), as well as any other relevant information **to or from** the following individual(s):

PROVIDER'S NAME	TITLE	CONTACT INFORMATION

Signature: _____ Date: _____
(parent to sign if minor)