cKAY NUTRITION

Release of Information (ROI)

I, _Type your name_, authorize Carolina Espinosa Rodriguez, MS, RDN
on _Type in Date_ to contact and/or release information concerning my health and nutrition therapy to the clinicians listed on this form. With knowledge that his authorization form can be withdrawn at the client's request at any time. When nutrition counseling treatment discontinues, this form will expire in 90 days after date of last session.

Provider Name (Physician, Psychiatrist, Therapist, etc.)	**Address**	**Phone #**	**Provider office website** (if available)

By signing below, I acknowledge I have read and understand the above statement that is in place to maintain my confidentiality and optimal care.

Client (Printed Name)	Client (Signature/Re-type full name if emailing)	Date