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## Mindful Nutrition Counseling Patient Release Authorization

I, the undersigned patient, authorize my registered dietitian of Mindful Nutrition Counseling, to consult with my therapist and/or other health care providers upon request or if deemed as necessary.

I understand that Mindful Nutrition Counseling will protect my privacy and that this information will be released to other health care professionals only when it is necessary to provide health care services to me. This authority shall continue until it is revoked by me in writing.

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

City, State,  
Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_