Erin Naimi, RDN, CEDRD
Nutrition Therapist
(310) 551-0233

Authorization for Release of Information

Client Name:____

Date of Birth:____

Phone Number:______________________________________

This release of information form authorizes information from my records (or my child's records) to be shared between **Erin Naimi, RDN, CEDRD** and the person/agency listed below. I understand this authorization will remain valid indeterminately from the date signed below, unless otherwise specified by myself (or my parent in writing).

I, _________________________________, hereby authorize **Erin Naimi, RDN, CEDRD**
(print client name)
to release information as specified below from my records to:

1. ____
Name of Practitioner / Telephone number

2. ____
Name of Practitioner / Telephone number

3. ____
Name of Practitioner / Telephone number

This authorization is limited to the following information/ records:

Medical
Nutrition
Psychological
Psychiatric
Other (please specify):_______________________________________

____
Signature of Client **Date**

____
Signature of Parent (if client is a minor) **Date**

Telephone (310) 551-0233 / Fax (310) 551-0123
ErinNaimi@gmail.com