BRG
Dietetics & Nutrition, P.C.

Bonnie R. Giller, MS, RD, CDN, CDE
Certified Diabetes Educator

Informed Consent Form

I was fully explained and understand the purpose of medical nutrition therapy and the benefits and risks, if any, associated with such therapy. I understand the results are not guaranteed.

Patient name_____Date_____

Patient signature_____

Medical Information Release Form

Please check one of the following choices regarding release of medical information.

____Yes, this information may be disclosed to my Primary Care Physician (PCP) and specialist physician(s) for the purpose of coordinating care.

____No, this information may not be disclosed to my Primary Care Physician (PCP) or specialist physician(s).

I authorize the release of all healthcare information to the following individual/family member:

Name_____ Relationship_____

Phone _____

I understand that I can change the choices I have made above and can execute a new Medical Information Release Form at any time.

Patient name_____Date_____

Patient signature_____

383 Plymouth Street West Hempstead, NY 11552 (516) 486-4569 Phone (516) 486-1792 Fax www.brghealth.com