Andrea Berez, MS, RDN

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I hereby authorize Andrea Berez, MS, RDN of to release/receive my medical information to/from the following person(s):

1. ____
   Relationship to Patient ________________________________
   Date:____________________

2. ____
   Relationship to Patient ________________________________
   Date:____________________

3. ____
   Relationship to Patient ________________________________
   Date:____________________

4. ____
   Relationship to Patient ________________________________
   Date:____________________

Patient Name: ______________________________

Signature: ________________________________

Date: ____________________________________