LeSash
NUTRITION & HEALTH

Authorization to Treat

Patient's name: _____ *D.O.B.* _____

I authorize Jennilyn Jackman Baptiste of LeSash Nutrition & Health, LLC to provide necessary treatment including measurements, individualized meal plans, nutrition education, recommendations and any other as may in her professional judgment be necessary.

---------- *Date:* _____
Patient's (or guardians') signature

Authorization To Release Health Care Information

Patient's name: _____ *D.O.B.* _____

I request and authorize Jennilyn Jackman Baptiste of LeSash Nutrition & Health, LLC to release healthcare information of the patient named above to the referring Physician and any other health professional I am referred to by Ms. Baptiste.

---------- *Date:* _____
Patient's or guardian's signature