4215 Convention Place
Pasco, WA 99301
(509) 416-8877

Please ☑ if you *have* or *have had* any of the following conditions or circumstances:

- ☐ Currently Undergoing Cancer Treatment
- ☐ Severe Liver Disease
- ☐ Severe Kidney Disease
- ☐ Diagnosis of Parkinson's
- ☐ Currently on Lithium Therapy
- ☐ Alzheimer's Disease
- ☐ History of Congestive Heart Failure
- ☐ Heart Attack within 6 Months
- ☐ Strict Vegan Lifestyle
- ☐ Currently Pregnant
- ☐ Currently Breast Feeding
- ☐ None of These Conditions Apply

Dieters with any of the medical conditions listed below will be sent to their primary care doctor or specialist along with the Ideal Protein Weight Loss Method Overview and the Authorization to Use Protected Health Information medical release form. Once signed, we ask that you follow up with our clinic prior to beginning the Ideal Protein Weight Loss Program.

- ☐ Arrhythmia (Abnormal Heart Rhythm)
- ☐ Blood Clot
- ☐ Coronary Artery Disease
- ☐ Heart Valve Problem
- ☐ Heart Valve Replacement
- ☐ History of Heart Attack (Cardiologist Approval)
- ☐ Pulmonary Embolism
- ☐ Stroke or Transient Ischemic Attack (TIA)
- ☐ Child Under Age 17 (Pediatrician Approval)
- ☐ Kidney Disease
- ☐ Kidney Transplant
- ☐ Gastric Ulcer
- ☐ History of Bariatric Surgery
- ☐ Epilepsy
- ☐ Hyperkalemia (High Potassium Level)
- ☐ Hypokalemia (Low Potassium Level)
- ☐ History of Cancer:
  - ☐ 5 Years or Less
  - ☐ More than 5 Years
- ☐ None of These Conditions Apply

*Please talk to an Ideal Protein Coach prior to your Initial Consultation if you have any questions regarding this Medical Condition Checklist or the accompanying Medical Release form.

DIETER SIGNATURE PRINTED NAME DATE

To Whom It May Concern:

I have reviewed the Ideal Protein Weight Loss Method Overview and approve_____ to participate in the Ideal Protein Weight Loss program.

PHYSICIAN/PROVIDER SIGNATURE PRINTED NAME DATE

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient making authorization:			
Full Name:			
Birth Date (MM/DD/YYYY):		Phone:	
Address:			
Healthcare provider or entity authorized to disclose this information:			
Clinic/Provider Name:			
Phone:		Fax:	
Address:			
Healthcare provider or entity authorized to use this information:			
Clinic/Provider Name:			
Phone:		Fax:	
Address:			
Specific information to be disclosed (check one):			
☐Medical record From: (Enter as MM/DD/YYYY)		To:	

☐Entire medical record, including patient histories, office notes, test results, radiology studies, films, referrals, consults, billing records, insurance records, and records received from other healthcare providers.

Reason for release of information: Participation in a supervised weight loss and wellness program.

The individual signing this form agrees to and acknowledges the following:

1. **Voluntary authorization:** This authorization is voluntary. Treatment, payment, enrollment, or eligibility for benefits (as applicable) will not be conditioned upon my signing this authorization form.
2. Eff**ective time period:** This authorization shall be in effect until the earlier of two (2) years after the death of the patient for whom the authorization is made or until the following specified date:_____
3. **Right to revoke:** I understand that I have the right to revoke this authorization at any time by writing to the healthcare provider or entity listed above. I understand that I may revoke this authorization except to the extent that action has already been taken based on this authorization.
4. **Signature authorization:** I have read this form and agree to the uses and disclosure of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission. I understand that information disclosure pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws.

Signatures:	
Patient/Legal Representative:	Date:
If Legal Representative, relationship to Patient:	
Witness (optional):	Date:

Note: A minor individual's signature may be required for the release of certain types of information, including, for example, the release of information related to certain conditions or circumstances. Please refer to the current laws in this regard and, if determined to be a requirement, have minor sign below.

Signature of minor (if applicable):	Date: