Physician or Health Care Professional Authorization of Need

I, ____________________________________ give my permission to release my health
(Signature)
condition information to Home Delivered Meals as verification of need for meals.

Physician ____

or

Health Care Professional ____

Reason for referral: Briefly state the reason why the above patient needs Home Delivered Meals.

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____ ____________________________________
Signature Date

Please return this form to:

Home Delivered Meals

Attn. J Brewer

P. O. Box 232

Lake Jackson, Texas 77566