DIETARY WAIVER

I, _____, understand that my physician for reasons of my health and medical treatment, has ordered a _____ diet due to a medical diagnosis of _____.

I understand that not following the prescribed diet will be detrimental to my health and well-being and could cause medical complications.

I do not wish to follow the diet that has been prescribed for me by my physician.

I have been advised to discuss my desires with my physician, my family members, and my other advisors.

I have been advised and understand that following my prescribed diet will not result in any additional cost or expense to me.

I also understand that Zepol Dietary Consults and _____ (health care centers name) are not responsible for any harm or injury that I may suffer as a result of my refusal to follow my prescribed diet, and hereby release them from any and all liability due to my refusal to follow my prescribed diet.

I therefore declare that it is not my intention to follow my prescribed diet and request that I be provided with substitute food.

_____ _____

Signature of Patient/Resident Date

_____ _____

Signature of Nurse Date

_____ _____

Witness Date