Dr. Name_____

Clinic Name_____

Clinic Address_____

City, State, Zip_____

Re: Permission for patient to participate in the Ideal Protein Weight Loss Method

Dear Doctor,

Your patient_____ has expressed a desire to participate in the Ideal Protein physician designed weight loss program. Because he/she is currently under your care, I would like your approval before starting him/her on the program. An overview of the Ideal Protein method is included as part of this letter. Dieters are seen weekly to monitor their progress. Since many patients who enter into our program are able to reduce or discontinue medications such as antihypertensives, oral hypoglycemics, insulin, etc.), _____ understands the importance of keeping your office informed of his/her progress, in the event a change in medication becomes necessary.

I would be happy to keep you informed of _____'s progress as well. If you agree that he/she may benefit from our program, please give him/her a "doctor's permission slip" to participate in the Ideal Protein Weight Loss Method. Thank you. _____ is very excited to begin, and I look forward to helping him/her with this undertaking.

If you have any questions or concerns, please do not hesitate to contact me.

Sincerely,

Name Audrey Calabrese - office manager Clinic Name The Devine Touch

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Email idealproteinri@yahoo.com