CONSENT FOR TREATMENT AND AUTHORIZATION OF COMMUNICATION

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Patient Name: _____ DOB: _____

Parent/Guardian: _____ (Applies only to patients under 18)

I hereby consent to participating in nutrition counseling with the above designated Dietitian and understand that all information I provide is private, confidential, and protected by law as described in their privacy practices. When necessary to coordinate my nutrition and healthcare, and as described in this office's privacy practices, my protected health information may be obtained from and/or provided to my:

☐ Primary Care Doctor: _____

Address: _____

_____

Phone: _____ Fax: _____

☐ Other (Relationship): _____

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

☐ Psychologist or Therapist: _____

Address: _____

_____

Phone: _____ Fax: _____

The above designated Dietitian is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to my Dietitian at the address above. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Patient Signature_____Date_____

Parent/Guardian Signature_____Date_____