Consent for Treatment and Authorization Form
for use of Protected Health Information

Patient Name: _____ DOB: _____

Parent/Guardian: _____ (applies only to patients under 18 years of age)

I hereby consent to participating in nutrition counseling and understand that all information I provide is private, confidential, and protected by law as described in the Notice of Privacy Practices.
I hereby authorize any insurance benefits to be paid directly to Melissa Snow, RD, LD Nutrition Therapist and recognize my responsibility to pay all non-covered services.
When necessary to coordinate my nutrition and healthcare, my protected health information may be obtained from and/or provided to my:

- Insurance Company

- Primary Care Doctor: _____
  Address: _____
  Phone: _____ Fax: _____

- Other Doctor (Relationship: _____)
  Name: _____
  Address: _____
  Phone: _____ Fax: _____

- Psychologist or Counselor: _____
  Address: _____
  Phone: _____ Fax: _____

Melissa Snow, RD, LD 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 Melissa Snow, RD, LD at the address below. 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 _____

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