NUTRITION
CONNECTIONS

Consent for Treatment and Authorization Form for the us of Protected Health Information

Patient Name:_____ DOB:_____

Parent/Guardian Name:_____
(Applies only if patient is under 18)

I hereby consent to participating in nutrition counseling with Laura May-Roelse, M.A. RD/LD and understand that all information I provide is private, confidential, and protected by law as described in the PIH Privacy Practices. When necessary to coordinate my nutrition and healthcare, and as described in the PIH Privacy Practices, my protected health information may be obtained from and/or provided to my:

Insurance Company:

Primary Care Doctor:
Address:
Phone:
Fax:

Other Doctor:
Name:
Address:
Phone:
Fax:

Psychologist or Counselor:
Address:
Phone:
Fax:

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Laura May-Roelse, M.A. 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 Laura May. 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_____
(If patient is under 18)

I hereby give permission for my child to receive nutrition counseling with *Laura May-Roelse ,M.A. RD/LD* without a parent or guardian present, and I release *Laura May-Roelse, M.A. RD/LD* from any and all liability for any incidents or injuries that may occur during my child's appointment or when my child is traveling to or from his/her appointment. I understand that information discussed during counseling sessions will not be released to parents against a minor child's will, except for information of a life-threatening nature. In all cases, a minor child will be encouraged to share appropriate information with a parent.
(Applies only to patients who are 16 or 17 years of age.)

Parent/Guardian Signature_____
Date_____