Taste Life Nutrition Therapy, LLC

Consent for Treatment and Authorization Form for Use of Protected Health Information- Release of Information

I consent to providing information to the dietitians at Taste Life Nutrition Therapy, LLC and understand that the information I provide is private, confidential, and protected under HIPAA. If the information I share is needed to coordinate my nutrition and overall care, it may be shared with and/or obtained from the following individuals:

Insurance Company _____ Member ID#_____

DOB (MM/DD/YY) _____

Address _____

Physician/Primary Care _____ P:_____ F: _____

Therapist_____ P:_____ F: _____

Additional _____ P:_____ F: _____

Additional _____ P:_____ F: _____

Additional _____ P:_____ F: _____

I give my dietitian at Taste Life Nutrition Therapy, LLC permission to communicate about any disclosed information with the providers/individuals listed above. **Initials** _____

I understand that virtual sessions, and electronic communications via email cannot be assured with confidentiality. I understand that no nutrition therapy will be provided over email or through virtual sessions. To protect your confidentiality, and to maintain a therapeutic relationship with my provider, I understand that I cannot be "friends" with my provider at Taste Life Nutrition Therapy, LLC on Facebook, LinkedIn, Snap Chat, or Instagram but that I can follow the Taste Life Nutrition Therapy, LLC professional accounts.

_____ _____

Signature of Client/Guardian **Date**

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Printed Name of Client