CONSENT FOR TREATMENT AND AUTHORIZATION OF COMMUNICATION

Monadnock Nutrition Services, LLC; 43 Grove St, Peterborough, NH 03458; Ph: 978-252-2450

Patient Name: ___________________________________ DOB: ________________

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

I hereby consent to participating in nutrition counseling with Monadnock Nutrition Services, LLC 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: ____________________________

Monadnock Nutrition Services, LLC 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___________________