HARMONIC, LLC.
NUTRITION & WELLNESS

CONSENT FOR TREATMENT AND AUTHORIZATION FORM FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB:_____

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

I hereby consent to participating in nutrition counseling at Harmonic Nutrition & Wellness and understand that all information I provide is private, confidential, and protected by law as described in the Harmonic Nutrition & Wellness Privacy Practices. When necessary to coordinate my nutrition and healthcare, and as described in the Harmonic Nutrition & Wellness, LLC 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 (Relationship: _____)
  Name: _____
  Address:_____
  _____
  Phone:_____ Fax: _____
- ❑ Psychologist or Counselor: _____
  Address:_____
  _____
  Phone:_____ Fax: _____

Harmonic Nutrition & Wellness 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 Harmonic Nutrition & Wellness 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 _____
(If patient is under 18)

I hereby give permission for my child to receive counseling at *Harmonic Nutrition & Wellness,* without a parent or guardian present, and I release *Harmonic Nutrition & Wellness* and its employees 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 _____