
**Consent for Treatment and Authorization Form for Use of Protected Health Information**

I hereby consent to participating in nutrition counseling at Meredith Magnini RD and understand that all information I provide is private, confidential, and protected by law. When necessary to coordinate my nutrition and healthcare, my protected health information may be obtained from and/or provided to my:

Physician: _____ Phone #_____

Therapist/Counselor: _____ Phone #_____

Additional Provider: _____ Phone # _____

I give my clinician permission to speak with and disclose my protected health information with the above-named treatment providers.

**Printed Name of Client: _____ Date: _____**

**Signature: _____ Date: _____**