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

I hereby consent to participating in nutrition counseling at INSPIRD Nutrition Consulting, LLC 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:

Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist/Counselor \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Additional Provider \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**Virtual Eating Disorder Recovery and Body Image Coaching-** Video conferencing may not be a confidential method of communication unless done through a HIPAA compliant telehealth platform. Please be advised that Skype, Google Hangout or FaceTime are not HIPAA compliant. Virtual sessions are eating disorder recovery and body image coaching only, no medical nutrition therapy is provided.

I acknowledge I have been provided a copy of INSPIRD Nutrition Consulting, LLC HIPAA Notice of Privacy Practices. A copy is available at [www.inspirdnutrition.com](http://www.inspirdnutrition.com) at all times.

**Printed Name of Client:**

**Signature of Client:** Date:

**Signature of Parent:**  Date:

**Or Guardian** (if < 18 yrs. old)