



Consent to Treat, Release of Information and Privacy Policy

Consent to Treatment:

I authorize and consent to treatment at NutriFit, Inc., which includes medical nutrition therapy, nutrition counseling, and nutrition education for the treatment of my condition or for preventative and wellness care.

Consent to Release Information:

I authorize NutriFit, Inc. to release information and/or provide copies of my medical records, including billing information, medical history and all diagnosis information for the purpose of communicating treatment and outcomes to my physician(s), therapist, or other care providers as appropriate.

I understand that my records are protected under Federal Confidentiality regulations and protected from further disclosures without specific consent unless otherwise provided for in the law. I may revoke my consent in writing at any time except to the extent that action has been taken in reliance upon it.

Agreement:

If you have read and understand the above, please sign and date below.

SIGNATURE _____

PRINTED NAME _____ DATE _____