



**Hawk Nutrition, LLC**  
"Helping You Fly Away From Diet Culture"

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

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

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

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

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

Psychiatrist \_\_\_\_\_ Phone# \_\_\_\_\_

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

I give Hawk Nutrition, LLC, permission to speak with and disclose my PHI with the above-named treatment providers. I have been provided with a copy of our HIPAA Notice of Privacy Practices form and a copy is also available upon request and is up in my office.

Client's Signature \_\_\_\_\_ Date \_\_\_\_\_

Printed Name of Client \_\_\_\_\_

Signature of Parent or Guardian if Client is under 18 years old \_\_\_\_\_

Date \_\_\_\_\_



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