nutrition sense
NUTRITIONAL COUNSELING

PRIVACY CONSENT

By signing below you authorize Nutrition Sense to release medical records pertaining to your treatment to any entity that is responsible for payment of the charges. You also authorize payment of benefits directly to Nutrition Sense.

You have the right to revoke this consent in writing and the revocation will be effective to the extent Nutrition Sense has acted in reliance on your consent.

Signature of Patient _____ Date _____

Signature of Guardian _____ Relationship to Patient _____
(if different from patient)

ACKNOWLEDGMENT OF ACCEPTANCE OF NOTICE OF PRIVACY PRACTICES

Printed Name _____ Date of Birth _____

I hereby acknowledge that Nutrition Sense has provided me with a copy of its Notice of Privacy Practices. I also understand that I am entitled to receive updates upon request if Nutrition Sense amends or changes its Notice of Privacy Practices in a material way. I understand that if I have questions or complaints I may contact:

Nutrition Sense
206.898.9369
shana@nutrition-sene.com

Signature _____ Date _____

Relationship to the Patient _____