

## Consent to Treat, Release of Information & Privacy Policy



### **Patient Condition of Out-patient Treatment:**

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

### **Patient Rights:**

I have received information regarding my rights and responsibilities. I certify fully that I have read and understand the above consent and conditions of treatment and that explanations therein referred were made.

### **Consent to Release Information:**

I authorize DuPage Dietitians to release information and/or provide copies of my medical records, including billing information, medical history and all diagnosis information for the purpose of communication 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 prohibit from making 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. This authorization for release expires 12 months after treatment is completed or until full payment is received, whichever is longer. Consent to release information for billing and payment purposes is contained in the financial policy.

### **Privacy Policy:**

I acknowledge that I have been given an opportunity to read DuPage Dietitians Notice of Privacy Practices. I understand it describes uses and disclosures of my protected health information by DuPage Dietitians and informs me of my rights with respect to my protected health information and that upon request, I can be provided with a copy of the policy.

**Please note: E-mails may be sent to the practice for scheduling purposes and to ask questions about care or billing. Please DO NOT cancel appointments by e-mail.**

### **Agreement:**

If you have read and understand the above, please sign and date below. If you have any questions, please ask for clarification.

Printed Name: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of parent or guardian of patient under age 18: \_\_\_\_\_

Date: \_\_\_\_\_