TKS Nutrition, LLC
Healthy Habits for Life

Authorization for Release of Patient Medical Information

To: _____
Name of Healthcare Provider/ Physician

_____
Street Address

_____ _____ _____ _____
City State Zip Code Phone Number

_____
Fax Number

Re: _____
Patient Name

_____
Street Address

_____ _____ _____
City State Zip Code

_____ _____
Date of Birth Phone Number

I authorize and request the disclosure of all protected information for the purpose of review and evaluation in connection with medical care. I expressly request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

Office notes (History & Physical, Past Medical History, recent office visits notes)
Diagnostic reports (x-ray, CAT scan, MRI, Swallow studies, Gastric Emptying studies, etc)
Laboratory results
Current medication list
Other: _____

To: TKS Nutrition, LLC
Tracey Sinibaldi, RD, LDN, CDE
244 Manchester Way
Middletown, DE 19709
(302) 897-2088
Fax: (302)376-9261

I understand that I may revoke this consent at any time by a written request but not retroactive to the release of information made in good faith. Otherwise, this release will expire at the time I am discharged from treatment. I also understand that disclosed information may be subject to rediscolsure by the recipient and no longer protected by this consent.

_____ _____
Signature of Patient or Legally Authorized Representative Date

_____
Printed name of Patient or Legally Authorized Representative

_____ _____
Witness Date

Revised July 2015