



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 redisclosure 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