Authorization to Release Medical Records

TKS Nutrition, LLC
Healthy Habits for LIFE

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Patient name:
Date of birth:
Address:
Phone number:

Authorized Healthcare Provider / Physician

I authorize the use and disclosure of _____ 's protected health information for the purpose of review and evaluation in connection with medical care to TKS Nutrition LLC; 244 Manchester Way, Middletown, DE 19709 ; Fax#: 302-376-9261.

1) Name of Healthcare provider / Physician:
Address:
Phone number:
Fax number:

2) Name of Healthcare Provider / Physician:
Address:
Phone number:
Fax Number:

3) Name of Healthcare Provider / Physician:
Address:
Phone number:
Fax number:

Effective Period

This authorization for the release of information covers the period of healthcare of all past, present and future periods.

Extent of Authorization

I authorize the release of my complete health record with the **exception** of the following information:

- Mental health records
- Communicable diseases (including HIV and AIDS)
- Alcohol/drug abuse & treatment

Agreement

I understand that I have the right to revoke this authorization, in writing, at anytime. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I agree: NO YES

Please Sign Below

Name: _____
Signature: _____
Date of birth: _____
Date Signed: _____