Date: _____

TKS Nutrition, LLC
Healthy Habits for LIFE

Tracey K Sinibaldi,RD,LDN,CDCES
Registered Dietitian
Certified Diabetes Care & Education Specialist

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tksnutrition@verizon.net
www.tksnutrition.com

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

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, parents or others to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give consent to release this information to the family members indicated below. This authorization shall be in force and effect for the duration of 60 months, at which time this authorization will expire.

You understand that information disclosed to any authorized recipient listed below is no longer protected by federal or state law and may be subject to redisclosure by the below recipient. You have the right to revoke this consent in writing.

Authorized Person

I authorize / allow Tracey Sinibaldi TKS Nutrition LLC to release _____ protected health information to the following individuals (s):

1) Name:
Address:
Phone number:
Date of Birth:

2) Name:
Address:
Phone Number:
Date of Birth:

3) Name:
Address:
Phone Number:
Date of Birth:

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.

Print Name: _____ **Date of Birth:** _____

Signature: _____