

Authorization to Release Medical Records



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 nutrition therapy 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 will expire either:

- 1 year from the date of signing or unless revoked by _____
 - Upon the termination of my treatment relationship with this Provider (for authorizations involving Treatment, Payment, and Health Care Operations).
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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
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Agreement

- 1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
- 2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
- 3) I may revoke this authorization at any time by notifying TKS Nutrition LLC in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
- 4) Information disclosed under this authorization is subject to re-disclosure by the recipient; however, records protected by 42 C.F.R. Part 2 (Substance Use Disorder records) may not be re-disclosed by the recipient without my specific written consent or as otherwise permitted by Part 2. Any information disclosed to health care providers, insurance companies, insurance agents and brokers, health plans and health plan administrators, will continue to be protected and not be reused or re-disclosed other than as authorized by me or permitted by law.
- 5) I understand that the organization will not sell my health information or use it for marketing purposes without my separate, specific written authorization.

- 6) If you are authorizing the release of Substance Use Disorder (SUD) records protected by federal law (42 C.F.R. Part 2):
- a. **No Further Sharing:** I understand the person or organization receiving these records is strictly prohibited from sharing them with anyone else unless I give new written permission or federal law specifically allows it.
 - b. **Not for Court or Police:** I understand these records cannot be used as evidence against me in a courtroom, by law enforcement, or in any other legal proceeding unless I give written permission or a judge issues a special federal court order.
- 7) If I am authorizing the disclosure of SUD records for Treatment, Payment, or Health Care Operations, I have the right to receive an accounting of such disclosures upon request.

I have read and understood the information above and with my signature below, authorize the receipt, use and disclosure of the information described in this document for the limited purposes identified herein. No promises or representations have been made to me to induce me to sign this form.

I agree: NO YES

Signature of Patient or Legal Representative: _____

Printed Name of Patient's Representative (if applicable): _____

Relationship: _____ **Date Signed:** _____