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 1 year from the date of signing or unless revoked by _______________________________.

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

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) TKS Nutrition LLC agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

I agree: NO YES

Signature of Patient or Legal Representative: ____

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

Relationship: _______________________________________ **Date Signed:** ______________________