CONSENT FORM

EMAIL or FAX COMPLETED FORM: orders@cambrooke.com f 978 443 1318

Patient Information and Consent

Patient's Name

Date of Birth

If a minor, Parent/Guardian/Caregiver Name

Diagnosis

Shipping Address (No P.O. box)

Phone

City

State, Zip Code

Email

☐ **Yes** The patient or guardian consents to the health professional indicated below disclosing personal information to Cambrooke Therapeutics for the purpose of directing Cambrooke in providing Cambrooke Medical Food(s). The patient or guardian also consents to Cambrooke Therapeutics collecting, using and disclosing the personal information for the purpose of providing the requested product.

Health Care Professional

Health Care Professional's Name

License Number

Medical Institution

Health Care Professional's Position

Email

Phone

I hereby confirm that the above patient is authorized to take: ______________________

Name of Cambrooke Medical Food

Signature

Order

☑ Consent to order the above Cambrooke Medical Food(s) through Cambrooke Therapeutics.

Form Submission

Please email or fax completed form: orders@cambrooke.com or 978 443 1318

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