New Order/Prescription Fax Form

FAX NUMBER: 1-636-614-0299

STEP 1
COMPLETE PATIENT INFO

Patient Name ______________________

Cell Phone # (______) ______ - ______ Date of Birth ______ / ______ / ______ (Month / Day / Year)

Email ______________________

Street Address ______________________

City ______________ State ______ Zip ______

STEP 2
SELECT PRODUCT

Central Nervous System Disorders

☐ **EB-H4** 200mg Riboflavin, 50mg CoQ10, 0.2mg L-methylfolate Ca,175mg Magnesium

Sig 2 capsules PO QD
Other Sig

Qty #180 Capsules (3 month supply)
Refills ☐ Auto Fill or other ☐ ______

☐ **EB-C3** 6mg L-methylfolate Calcium, 2mg Methylcobalamin, 600mg N-Acetyl L-Cysteine

Sig 1 capsule PO QD
Other Sig

Qty #90 Capsules (3 month supply)
Refills ☐ Auto Fill or other ☐ ______

Peripheral Neuropathic Complications

☐ **EB-N3** 6mg L-methylfolate Calcium, 4mg Methylcobalamin, 70mg Pyridoxal 5-Phosphate

Sig 1 capsule PO QD
Other Sig

Qty #90 Capsules (3 month supply)
Refills ☐ Auto Fill or other ☐ ______

STEP 3
COMPLETE PROVIDER INFO

FAX TO 1-636-614-0299

HCP Name	NPI # (Required)	License #	HCP Name	NPI # (Required)	License #
☐ Merle L. Diamond, MD	1780676668		☐ George J. Urban, MD	1639161524	
☐ Alex Feoktistov, MD, PhD	1003143801		☐ Bradley D. Torphy, MD	1104052372	

Office Contact Name Jacquelyn Fernandez Phone 773-388-6390 Fax 312-867-7101

Address 1460 N. Halsted Street, Suite 501 City Chicago State IL Zip 60642

SIGNATURE

______________________ Signature or Stamp Acceptable

______________ Date

FAX: 1-636-614-0299 | Phone: 1-636-614-3152 | Email: support@EBMmedical.com

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Diamond Headache Clinic

HIPAA PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

The Health Insurance Portability and Accountability governs your physician's and Diamond Headache Clinic's (collectively "DHC") use and disclosure of your Protected Health Information ("PHI"). Generally, except as otherwise permitted by law, DHC cannot disclose your PHI to another person without your prior written authorization. By signing this Authorization, you are authorizing DHC to release your PHI to the persons or entities described below.

Authorized Disclosing Individual/Entity: I, ____ , hereby authorize Diamond Headache Clinic Ltd., 1460 North Halsted St., Ste. 501, Chicago IL, 60642, to use and disclose my PHI as described in this Authorization.

Authorized Recipient: I hereby authorize DHC to use my PHI and to disclose my PHI to GKM Health, LLC and its affiliates and subcontractors ("GKM").

Information to be Disclosed: I hereby authorize the following PHI to be disclosed: my name, contact information, and medical condition which merits recommendation of certain medical food dietary supplement products (the "Products").

Purpose(s) for the Disclosure: I hereby authorize this disclosure for use by GKM to contact me regarding purchase of the Products, and for assistance provided to DHC facilitating medical supervision of my use of the Products. I understand that DHC may receive remuneration in connection with my purchase of the Products.

My Rights: I understand that authorizing this disclosure of PHI is voluntary. My treatment, payment, enrollment in a health plan, or eligibility for benefits, will not be conditioned upon my signing this Authorization. I understand that I may revoke this authorization at any time by delivering a revocation in writing to Diamond Headache Clinic, and if I revoke this authorization, it will have no effect on actions already taken by Diamond Headache Clinic in reliance on this authorization. I understand that my revocation of this Authorization will become effective upon DHC' s receipt of the revocation notice, but that GKM may continue to contact me following a purchase of the Products without requiring use of my PHI. I understand that I have the right to inspect or obtain a copy of the PHI to be used and disclosed through this Authorization. I understand that DHC must provide me with a copy of this signed authorization, upon request.

Expiration: This Authorization will expire five (5) years following the date of my signature, or on such date that I turn down GKM's offer to purchase Products, unless I revoke this Authorization sooner. I authorize the disclosure described herein. I have read and understand this authorization. I am the patient listed on this authorization or am authorized to act on behalf of the patient as the patient's personal representative.

Signature of Patient or Personal Representative: ______________________________

Patient Name: ____ Date: __________

DOB: ______________________________ Phone: ______________________________

Printed Name of Patient or Personal Representative (if applicable): ____________________

Description of Personal Representative’s Authority (if applicable): ____________________