CAMBROOKE™

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 Ajinomoto Cambrooke for the purpose of directing Cambrooke in providing Cambrooke Medical Food(s). The patient or guardian also consents to Ajinomoto Cambrooke 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 Ajinomoto Cambrooke.

Form Submission

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