Monte Nido & Affiliates
Treating Eating Disorders

CONSENT TO RELEASE MEDICAL RECORD INFORMATION

I_____ (client name, or guardian - printed), hereby authorize Monte Nido & Affiliates and the following party: (to whom records shall be released) _____

Facility where treatment was rendered:_____

Name:_____Relation to Client: _____

E-Mail:_____Phone:_____

Address (to be mailed):_____

_____

_____

Attn:

_____

and their respective agents, and/or employees, to disclose to and/or obtain from each other copies of any and all information and/or records regarding my psychological and mental diagnosis and treatment and other pertinent information relative to my past, present, or future condition. I realize that the exchange and disclosure of information between each of such parties is for the purpose of assisting all involved in properly treating me and facilitating transition of care.

Please note that the medical records request may take up to 30 days for processing.

Reason:

____Continuum of Care (ongoing treatment) ____Disability ____Litigation ____Personal/Other _____

Please release the following: (check all that apply)

__ Assessments (Biopsychsocial, History and Physical, Psychiatric, Nutritional)
__ Master Treatment Plan/Treatment Plan updates
__ Nutritional Summary
__ Medical Summary/Medications
__ Labs/Reports
__ Discharge Summary
__ Aftercare Recommendations
__ All documents listed above
Other (please list) _____

I understand that authorizing the disclosure of this information is voluntary. I can refuse to sign this authorization. I may also request that only specific information is communicated. Furthermore, I understand that I may revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the applicable parties named herein. I understand that the revocation will not apply to information-which has already been released in response to prior authorization.

Additionally, I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules. Please find the HIPAA website and their policy concerning medical records.
http://www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/medicalrecords.html

This authorization expires automatically one (1) year from the date signed (___/___/___ - ___/___/___) unless designated otherwise (___/___/___) – (___/___/___). I have received a copy of the signed authorization.

_____ _____
Client Name (Printed) Date of Birth

_____ _____
Client Signature/ Legal Guardian Signature (when applicable) Date