Center for Eating Disorders Management

Email Completed and Signed form to:
medicalrecords@refreshmentalhealth.com

Authorization for Release of Protected Health Information (PHI)

Center for Eating Disorders Management (CEDM), on behalf of itself and affiliated companies, cannot disclose PHI without consent from the patient that the information is about. We use this form to obtain your written consent to disclose your protected health information to the recipient(s) of your choice. This request does not allow the recipient to make any of your treatment decisions or direct care decisions. Use this form to consent to the release of verbal or written PHI, to the person, named in Section 2 below. When filling out this form, provide your most current information.

1. Patient Information (please provide current information)

Last Name	First Name	Middle Initial

Mailing Street Address	Apt. #

City	State	Zip

Date of Birth (mm / dd / yyyy)	Phone Number with Area Code

2. Send my medical records to:

I authorize CEDM to use and disclose my PHI to the person(s) or organization(s) designated below. I understand that there are certain parties that must protect the privacy of my PHI. These are health care providers and other parties who are required to do so under federal or related state laws. If my designated person is not a health care provider or another party required to protect my PHI, it could be discussed and/or released by them without my permission.

Recipient #1

Name	Relationship to Patient

Mailing Street Address	Apt. #

City	State	Zip

Phone Number with Area Code	Fax Number with Area Code

Recipient #2

Name	Relationship to Patient

Mailing Street Address	Apt. #

City	State	Zip

Phone Number with Area Code	Fax Number with Area Code

3. Description and Purpose of Disclosure

I authorize CEDM to:	**The following items require special consent by law.**
☐ Send my Medical Records to the recipient(s) listed in **Section 2**	Check the boxes below to indicate your intent to include:
☐ Request my medical records from the recipient(s) listed in **Section 2**	☐ Alcohol or Substance Use ☐ Genetic Information ☐ HIV/AIDS ☐ Mental or Behavioral Health ☐ Reproductive Health

Please describe the health information to be disclosed, and the purpose of the disclosure. I understand that by leaving this section blank, I am authorizing the disclosure of all of my PHI, to my authorized recipient(s).

Description:

4. Expiration and Revocation

I understand that this consent will expire thirty-six (36) months from the date of my signature as noted below unless I revoke in writing, request a different date below, or am a resident of a state that requires a shorter timeframe.

If I wish for my consent to expire on a different date, noted here: _____

For those residing in states below, the expiration date cannot exceed:

12 Months: MD, MN **24 Months**: MT, VA, Puerto Rico **30 Months**: ME

5. Signature(s)

A. Authorized person designated by patient:
I have read and understand the above information. I acknowledge that by signing this form, I understand that my decision of whether to sign this form will not affect my eligibility for treatment or payment and am voluntarily giving consent to CEDM to use and/or disclose my PHI to the person(s) or organization(s) designated in **Section 2**.

_____ _____
Signature of Patient **Date:**

B. Personal representatives who are legally appointed:
I have read and understand the request and acknowledge that by signing this form I have the legal authority to act on behalf of the member or patient and am attaching the appropriate documentation to this request.

_____ _____
Signature of Personal Representative **Date:**

Please Return this Completed Form to:

medicalrecords@refreshmentalhealth.com

Please keep a copy of this form for your records.