AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient's Name: _____ MR _____ DOB _____

Address: _____
Street City State Zip Code

Phone number Dates of Service Purpose of Disclosure

To the party receiving this information: If the records disclosed to you pursuant to this authorization contain information related to alcohol and/or drug abuse, HIV/AIDS related information, confidential communicable disease information, and/or psychiatric mental health information, the information has been disclosed to you from records protected by Federal confidentiality rules (42 C.F.R. Part 2) or by Arizona and Virginia Law. The Federal and state rules prohibit you from making any further disclosure of such information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If this consent was given pursuant to 42 C.F.R. Part 2 for disclosure pertaining to alcohol and/or drug abuse, HIV/AIDS related information, confidential communicable disease information, and/or psychiatric mental health information, it is subject to revocation by me at any time except to the extent that action has been taken in reliance thereon and in any event, subject to the foregoing exception, this authorization will automatically expire I year from the date on which it was signed.

- ☐ Primary Care Provider Packet (Integrated Discharge Summary, Medical & Physical Examination, Physician's Orders, Labs, EKG, DEXA Scan)
- ☐ Nutrition Packet (Integrated Discharge Summary, Nutritional Assessment, Discharge Meal Plan)
- ☐ Psychiatric Provider Packet (Integrated Discharge Summary, Psychiatric Evaluation, Psychological Evaluation, Psychosocial Assessment Summary, Family Progress Note)
- ☐ Primary Therapist Packet (Integrated Discharge Summary, Psychological Evaluation, Psychosocial Assessment Summary, Psychiatric Evaluation, Family Progress Note)
- ☐ Family Therapist Packet (Integrated Discharge Summary, Family week Progress Note, Psychosocial Assessment Summary)
- ☐ Integrated Discharge Summary
- ☐ Physician's Orders
- ☐ History and Physical Exam
- ☐ Nutritional Assessment
- ☐ Clinical Progress Notes
- ☐ Psychological Evaluation
- ☐ EKG/EEG
- ☐ Psychosocial History
- ☐ Psychiatric Evaluation
- ☐ Nutrition Progress Notes
- ☐ Psychiatric Progress Notes
- ☐ Lab Reports and Radiology
- ☐ Family Week Progress Note
- ☐ Meal Plan
- ☐ Two-way communication between releasing and receiving parties
- ☐ Other (specify)

I hereby authorize

Remuda Ranch Center for Anorexia and Bulimia, Inc.
Facility Releasing Information

1 E. Apache Street Wickenburg, Arizona 85390
Street City State Zip Code

(initial one space) to _____ release; _____ obtain; _____ release to and obtain all of the above requested information to/from:

_____
Person/Facility/Company Receiving Information Phone number

_____
Street City State Zip Code

* I understand that the information to be released may contain confidential HIV/AIDS related information, confidential communicable disease information, information relating to drug/alcohol use/abuse/treatment** and/or psychiatric mental health information. I authorize the release of the above indicated confidential information. I understand that Remuda Ranch Treatment Center will not condition treatment on my signing this authorization. Remuda will not deny me treatment if I do not wish to sign this form. I may refuse to sign this authorization form. I have the right to revoke this Authorization at any time by doing so in writing. [Please see the Remuda Ranch Notice of Privacy Practices for details on that right]. I understand that, if this information is disclosed to a third party, the information may no longer be protected by the federal privacy regulations and may be redisclosed by the person or organization who receives the information. I understand the matters discussed on this form. I release the provider, its employees, officers and directors, medical staff members, and business associates from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein.

_____ _____
Signature of Patient Date

** If patient is a minor and information is to be released regarding treatment for alcohol or drug abuse, both the patient and the parent or guardian must sign.

_____
Signature of Parent or Guardian/Relationship to Patient

_____
Witness

REMUDA
Nourishment for Life
Programs for Eating Disorders

RELEASE OF INFORMATION