Authorization for Release of Protected Health or Mental Health Information

Completion of this form authorizes the release of information described in the section below called "specific description of records authorized for release."

Person Whose Records Will be Released (Client)

Name:_____ Date of Birth: _____

The undersigned authorizes Robyn L. Goldberg, RDN, CEDRD-S and Colleagues at The Eating Disorder Trap, Inc. to (check all that apply)

☐ Release Information To ☐ Obtain Information From

The following person or agency:

Name		**Provider Type**	
Address		**E-mail**	
Phone #		**Fax #**	

Name		**Provider Type**	
Address		**E-mail**	
Phone #		**Fax #**	

Name		**Provider Type**	
Address		**E-mail**	
Phone #		**Fax #**	

Information authorized for release between the above noted agency or individual and Robyn L. Goldberg, RDN, CEDRD-S, and colleagues at The Eating Disorder Trap, Inc.(check yes or no)

☐**No** ☐**Yes**	Diagnosis
☐**No** ☐**Yes**	Psychological History
☐**No** ☐**Yes**	Progress Notes
☐**No** ☐**Yes**	Medical History
☐**No** ☐**Yes**	Treatment Plan and Goals
☐**No** ☐**Yes**	Nutritional History
☐**No** ☐**Yes**	Other (Specify): _____

The information being disclosed may only be used for the following specific purpose:_____

_____

Initials of Client or Legal Representative: _____

Understandings and Signature:

- This authorization is voluntary. Refusal to sign will not affect treatment, payment or services.
- You have a right to receive a copy of this authorization upon request.
- Other information that you authorize to be released may only be redisclosed by the recipient of the records if allowed by law. If the information is redisclosed, the recipient of the redisclosed information may be controlled by different laws.
- The person or entity requesting the information will destroy the information and all copies in the person's or entity's possession or control, will cause it to be destroyed, or will return the information and all copies of it before or immediately after the length of time specified below has expired:
    - If the recipient of the information is an entity covered by HIPAA (e.g. a doctor), they will store the information they receive in accordance with their internal record retention policy.
    - Other persons or entities shall destroy the information after a period of time not to exceed 1 year, unless another date is specified here: _____

- You may revoke this authorization by notifying The Eating Disorder Trap, Inc. Robyn L. Goldberg, RDN, CEDRD-S in writing at any time. The revocation will not apply to information already released as a result of this authorization.
- Unless revoked, this authorization will remain in effect for 12 months from the date this form was signed, unless a different date is specified here: _____

By signing below, you consent to the release of protected health information as described in this document.

Signature of Client: _____ Date: _____

Legal Representative Name: _____

Signature: _____Date:_____