Atlanta Center for Eating Disorders

4536 Barclay Drive, Suite A, Atlanta, GA 30338
(770) 458-8711 fax (770) 458-8640

Consent for Release of Information

Patient's Full Name:_____ Date of birth:_____

To the Patient: We at ACE are very conscientious about maintaining patient confidentiality while coordinating your care with others. **Please list any physicians, psychiatrists, or mental health therapists that you have seen in the last two years**. Please also list any family members with whom you think we may need to be in contact.

Professionals Seen	City	State	Phone Number	Reason

Family Members	City	State	Phone Number	Relationship

PURPOSE FOR CONSENT: To assist the ACE clinical staff in the evaluation and/or treatment of the patient's presenting concerns, to be informed of or to coordinate treatment with other health care or mental health professionals, and to facilitate continuity of care during discharge planning.

SPECIFIC INFORMATION TO BE RELEASED OR RECEIVED: The information exchanged with other health care or mental health professionals could include the following: results of psychological testing, results of medical examination or testing, diagnoses, names of other mental health care or health care providers, treatment plans, recommendations for current treatment, statement of progress in treatment, prognosis, discharge summary, and discharge recommendations.

I hereby request and/or consent for the clinical staff at ACE to release and obtain the above information regarding my dependent, or myself. I understand that this information may include information and records protected under Federal Law (such as alcohol and drug abuse treatment information) and/or protected under State Law (such as regarding mental health treatment, mental retardation, privileged communications, communicable or infectious diseases, alcohol/drug abuse, AIDS (acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus). I also understand that I may cancel this consent at any time in writing. However, the revocation will not be effective to the extent that ACE has taken action in reliance on the consent. Unless I specify otherwise, this authorization is in effect for the duration of my treatment at ACE and it automatically expires six months after my termination of services.

The following are clinicians I have seen in the past two years or family members whom I do not give my consent for you to contact. (Please note that ACE may deny treatment in some cases when not given permission to contact other clinicians who have been or are involved in your care.)

Name	City	State	Phone Number	Reason Seen/Relationship

_____ _____ _____ _____
Patient Signature Date Witness Date

_____ _____ _____
Parent/Guardian Signature Date Relationship to Patient