Medical Center for Eating Disorders

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Phone: 713-956-4083 Fax: 832-916-2033

Patient Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone Number: _____

___ I authorize Medical Center for Eating Disorders to obtain information from

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone #/Fax # (include area code)

AND/OR

___ I authorize Medical Center for Eating Disorders to release information to:

_____
Name of Provider or Facility

_____
Address

_____
City, State, Zip

_____
Phone #/Fax # (include area code)

Purpose of this request: _____
_____

Specific Information Authorized (select one or more as appropriate):

___ History & Physical
___ Operative Reports
___ Laboratory Results
___ Emergency Room Reports
___ Diagnostic Reports (i.e., EKG, EEG, Sleep Study)
___ Consultation Reports
___ Radiology Reports
___ Pathology Reports
___ Other:_____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Medical Center for Eating Disorders, except where a disclosure has already been made in reliance on my prior authorization.
- Release of HIV-related information requires additional information.

Expiration of Authorization:
Unless otherwise revoked, this authorization expires _____ (Insert applicable date or event).
If no date is indicated, this authorization will expire 12 months after the date of signing this form.

_____ _____
Patient Signature Date

_____ _____
Guardian Signature Date