McCallum Place
Eating Disorder Centers
St. Louis • Columbia • Austin • Kansas City

AUTHORIZATION TO DISCLOSE HEALTHCARE INFORMATION

Instructions: Fill in the appropriate information in each applicable section. Sign, date, and return the form. Incomplete forms will be returned to you unprocessed. A separate authorization must be completed for each request.

Patient Full Name: _____ Date of Birth:_____ Phone Number:_____
Address:_____

I hereby authorize: __release information to: __exchange information

NAME: MCCALLUM PLACE	**NAME:**
ADDRESS: 231 WEST LOCKWOOD AVE, SUITE 201	**ADDRESS:**
ST. LOUIS, MO 63119	
PHONE: 314-968-1900 FAX: 314-968-1901	**PHONE: FAX:**

By signing below, I hereby authorize McCallum Place or agent, to disclose information contained in the medical and financial record of the patient identified above, which includes information that may be stored in a paper and/or other electronic format. However, such notes may contain information on general medical care; alcohol and drug abuse treatment; psychological and social work counseling; human immunodeficiency virus (HIV) or acquired immune deficiency syndrome (AIDS), or AIDS related complex. Including communicable diseases or infections, sexually transmitted diseases, venereal diseases, tuberculosis and hepatitis; demographic information; and treatment received at other health care facilities. Disclosure shall be limited to the following specific information contained in my records and/or obtained during the course of my diagnosis and treatment.

The following information is requested: (patient* or legal guardian √ items to be released).

__Psychiatric Evaluation
__History & Physical
__Practitioner Orders
__Practitioner Progress Notes
__Discharge Summary
__Laboratory Reports
__Immunization Records
__Medication Records
__Treatment/Individualized Service Plan
__Discharge Instructions
___Financial Account information
___Other (specify)_____
_____
_____
_____

The Purpose or Need for Disclosure is:

__To Transfer Client Care
__For Follow Up Care
__To Inform Family
__Referral Source
__Legal/Court System
__To Aid in Treatment
__For Discharge Planning
__To Update Medical Records
__Employer
__Application for Provider Coverage
__Psychological Report
__To Aid in financial account activity
__Other (specify) _____

I understand that the information in my health record may include information relating to sexually transmitted disease, immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. ***State and federal law protect the following information. If this information applies to you, please (√) indicate if you would like this information released/obtained*** (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records __ Yes __ No Dates: _____
HIV Testing and Results __ Yes __ No Dates: _____
Mental Health Records Dates: __ Yes __ No Dates: _____

Disclosure Format (Paper/US Mail or Fax is default if not marked.): Specify ¨E-mail" or other Electronic format¨: _____
This authorization is valid only if received within 60 days of being signed. This authorization will expire at the time of disclosure of requested information or on _____ (date cannot be more than 180 days after date signed below).

- I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation.
- I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient, and ay no longer be protected by federal and state privacy laws and regulations.
- I understand that McCallum Place will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

By signing below I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I also expressly consent and authorize to be contacted by the phone number provided (cellular or residential) by any type of voice method and by auto-dialer technology for any permissible purpose.

_____ _____
Patient or Authorized Representative Signature Date

_____
Print Name Relationship to Patient (if applicable).

Notice to Recipient: This authorization provides for a ·release of information about an individual whose confidentiality is protected by federal and state laws and regulation, including the Health Insurance Portability and Accountability Act of 1996 (45 C.F.R. §160-164) as well as 42 C.F.R part 2 and 42 U.S.C. §. §290dd-2, and state confidentiality laws. No information disclosed from this authorization may be re-disclosed without the specific written consent of the individual about whom such information pertains.