Eating Disorders Treatment Center, LLC

CONSENT FOR RELEASE OF INFORMATION

I _____(Print Name of Patient or Parent/Guardian) give consent for EDTC, LLC to exchange any and all information (including that relating to substance abuse and medical conditions) pertaining to my therapy, to the extent such disclosure is necessary for coordination of treatment, case management, claims processing, quality assurance, or utilization review purposes.

I understand that:

- I can revoke my consent at any time by submitting a written request to that effect, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent.
- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- Release of HIV related information requires additional information.
- This authorization expires _____ (insert applicable date or event) or if no date is indicated, 12 months from the date of signing this form.

With the following specific exception of information and/or persons:

_____,

I authorize EDTC, LLC to exchange information with:

My signature below indicates that I have read and understand the stipulations above.

Name and Relationship to Patient	Telephone & Fax Numbers	Email	Date of consent	Patient Initials

PATIENT SIGNATURE: _____Date:_____

PARENT OR GUARDIAN SIGNATURE: _____ Date: _____

EDTC, LLC Representative: _____ Date: _____