Canopy Cove Eating Disorder Treatment Center

Authorization for Release of Information and Records

I understand that under Florida law and federal HIPAA requirements, communications between a patient and his or her psychologist are privileged and may not be disclosed by the mental health provider unless the patient consents. I also understand that patient records maintained by a mental health provider may not be disclosed to third parties except with the patient's consent or through legal process.

I hereby authorize Canopy Cove to disclose and/or release verbal or written communications, and/or obtain records to/from the following:

Adult:
I, _____agree to be treated by Dr. Morse (Physician) and staff and by Dr. Chason (Psychiatrist) as recommended by my treatment team. I further authorize Canopy Cove to disclose and/or release verbal or written communications, and/or obtain records to/from Tallahassee Primary Care Associates and staff, Tallahassee Memorial HealthCare and staff, Capital Regional Medical Center and staff, and Apalachee Center and staff, Patient's First, Walmart, and Abilify Assistance Program as required for my well being.

_____ __ _____
Client Date

_____ _____
Witness Date

Parent of minor child:
I agree to allow my child _____ to be treated by Dr. Morse (Physician) and staff and by Dr. Chason (Psychiatrist) as recommended by my child's treatment team. I further authorize Canopy Cove to disclose and/or release verbal or written communications, and/or obtain records to/from the Tallahassee Memorial HealthCare and staff, and Capital Regional Medical Center and staff as required for my child's well being.

_____ _____
Parent or Guardian Date

_____ _____
Witness Date

My Insurance Company _____Phone _____

My physician_____Phone _____

My previous or future therapist/ psychiatrist/dietitian _____ Phone _____

My family members_____Phone _____

The person who referred me _____ Phone _____

Others as listed_____Phone _____

I authorize Canopy Cove to obtain and/or release the following information:

☐	Verbal Exchange	☐	Treatment Summary	☐	Physician Orders	☐	Other:_____
☐	Admission Evaluations	☐	Treatment Plans	☐	Medical Records	☐	Other:_____
☐	Psychological Testing	☐	Progress Notes	☐	Radiology/Lab Results	☐	Other:_____
☐	Psychiatric Evaluation	☐	Discharge Summary	☐	Medication Records		

Canopy Cove clients, please indicate your preferences below so that our office staff members may assist you better.
Example*:* ***Standard message:*** *"This is Sarah. Please call me at 893-8800.*
Confirmation message: *"This is Sarah. I'm calling to remind you of your appointment, Friday at 10AM. Thank you."*

May we call you at your place of employment?	No____	Standard Message Only____	Confirmation Message OK____
May we leave a message on your answering machine?	No____	Standard Message Only____	Confirmation Message OK____

Mail / Deliveries can be accepted on my behalf from the following individuals:
My family members_____
Others as listed_____
- OR –
Please accept all Mail/Deliveries on my behalf without any restrictions _____ Client Initials-or-Parent/Guardian Initials

This authorization is only for the limited purpose of releasing written communication to and discussing my case with these individuals or companies for the purposes of evaluation and treatment. It shall not be deemed a waiver of any privileged communications or confidential information. Restrictions on Re-Disclosure - When records are released, Canopy Cove, by written notice, advise the person receiving the records that re-disclosure with-out the consent of the person who is the subject of the records, or as otherwise approved by law, is prohibited.
*__This authorization shall remain in effect for 1 year or until revoked by me in writing.__

_____ _____
(Please Print) First, Middle, and Last Name Client's Date of Birth

_____ _____
Client Signature or Parent/Guardian of Minor Child Date Witness Date