Avalon Eating Disorder Treatment Centers

346 Harris Hill Road
Williamsville, New York 14221-7407
(716) 839-0999 Fax (716) 839-2058

All Inclusive

Client Name:_____
Date of Birth:_____
Social Security Number:_____

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Notice: This authorization ***cannot*** be used to disclose HIV-related information, ***nor*** for the re-disclosure of protected health information provided to Avalon by other individuals or agencies.

I, _____ do hereby authorize AVALON to release/obtain the identified information for the purpose of assessment for treatment, treatment planning and coordination of treatment with other treatment providers.

Obtain	Release	
☐	☐	Identifying information (such as name, address, telephone, age, sex, race)
☐	☐	Medical history/physical examination/medications/labs
☐	☐	Diagnosis/prognosis/progress in treatment
☐	☐	Admission Form/psychosocial assessment
☐	☐	Treatment Plan/Discharge Summary
☐	☐	Other: _____

For the purpose of gathering or sharing protected health information to coordinate treatment efforts or to (complete as appropriate) _____.

_____
Person/Agency you are obtaining or releasing information to. (Relationship)

_____
Street Address

_____
City State Zip Code

_____
Phone Numbers

I understand that any disclosure is bound by the Health Insurance Portability and Accountability Act (HIPPA), and Mental Hygiene Law Section 33.13, and that re-disclosure of this information without my additional written authorization is prohibited. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it by notifying my counselor/doctor or Avalon's Privacy Officer at 891-0999. This consent will automatically expire seven (7) months after the date of this consent, or on the following earlier date, event, or condition_____.

_____ _____
Signature of Client Date Signature of Parent/Legal Guardian/Representative Date

_____
Witness Signature Date