AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I, _____, whose date of birth is _____ authorize the disclosure of my protected health information as described herein. I understand that this authorization is voluntary and made to confirm my directions. I understand that, if the person(s) or organization(s) that I authorize to receive my protected health information are not subject to federal and state health information privacy laws, subsequent disclosure by such person(s) or organization(s) may not be protected by those laws.

I authorize the following person(s) and/or organization(s) to disclose my protected health information(as specified below):

Altering Disordered Eating, Inc.
Dr. Martha Ireland
23077 Charmay Pond Place
Ashburn, VA 20148
703-722-2324
703-327-6933 (Fax)

I authorize the following person(s) and/or organizations to receive my protected health information as disclosed by the person(s) and/or organizations(s) above.

_____
_____
_____

Description of Information to be Disclosed
(Patient/Client should initial each item to be disclosed.)

____ Assessment
____ Diagnosis
____ Psychosocial Evaluation
____ Psychological Evaluation
____ Treatment Plan or Summary
____ Current Treatment Update
____ Testing Information
____ Educational Information
____ Presence/Participation in Treatment
____ Continuing Care Plan
____ Progress in Treatment
____ Other _____

The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify: _____
_____

I understand the information released may include information that may indicate the presence of communicable or venereal diseases which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the Human Immune Deficiency Virus also known as Acquired Immune Deficiency Syndrome("AIDS").

Initials: _____
Date: _____

I understand that I may revoke this authorization in writing at any time, except to the extent that the person(s) and/or organization(s) named above have taken action in reliance on this authorization. Unless sooner revoked, this authorization expires on _____, or as otherwise indicated: _____

I further understand that Dr. Ireland will not condition my treatment on whether I give authorization for the requested disclosure.

Disclosure by third parties: Federal and state laws protect the information disclosed pursuant to this Authorization. I understand that if the authorized recipient of the information is not a health care provider or health care plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I further understand that I need not sign this Authorization in order to ensure health care treatment, payment, enrollment in a health plan, or eligibility for benefits. I acknowledge that I have been informed of my right to be given a copy of this Authorization after signing it.

I hereby, knowingly and voluntarily, authorize to use or disclose my health information in the manner described above.

Patient Signature: _____ Date: _____

If individual is a minor or is otherwise unable to sign this Authorization

Signature of Guardian/Representative:_____Date:_____

Relationship / Authority: _____