Authorization for Disclosure

Of Protected Health Information

ADE, Inc.
Martha H. Ireland, PhD, RN, CS
165 Topside E.
Hardeeville, SC 29927
(703) 722-2324 | info@irelandphd.com

CLIENT NAME | DATE OF BIRTH | TODAY'S DATE

I authorize the disclosure of my protected health information as described below. I understand that this authorization is voluntary and is made to confirm my own directions. I understand that if the person or organization I authorize to receive my information is not subject to federal and state health information privacy laws, any further disclosure they make may not be protected by those laws.

DISCLOSING PARTY

Altering Disordered Eating, Inc. | Dr. Martha Ireland | 165 Topside E., Hardeeville, SC 29927 | (703) 722-2324 | info@irelandphd.com

RECEIVING PARTY

Information may be released to, and requested from, the person or organization named below. Check the direction of exchange you are authorizing.

☐ Release information to them ☐ Request information from them ☐ Two-way exchange of information

NAME	ROLE OR ORGANIZATION	PHONE	ADDRESS OR SECURE EMAIL

INFORMATION TO BE DISCLOSED

Please initial each item you are authorizing. Anything not initialed will not be shared.

- ☐ Assessment
- ☐ Diagnosis
- ☐ Psychosocial evaluation
- ☐ Psychological evaluation
- ☐ Treatment plan or summary
- ☐ Current treatment update
- ☐ Testing information
- ☐ Educational information
- ☐ Presence and participation in treatment
- ☐ Continuing care plan
- ☐ Progress in treatment
- ☐ Other

IF OTHER, SPECIFY | YOUR INITIALS

You may exclude specific topics from this authorization. Anything you list below will not be disclosed even if it falls within a category you initialed above.

INFORMATION I DO NOT WANT DISCLOSED

PURPOSE OF DISCLOSURE

The purpose of this disclosure is to improve assessment and treatment planning, to share information relevant to treatment, and where appropriate to coordinate treatment services.

IF THE PURPOSE IS SOMETHING ELSE, DESCRIBE IT HERE

I understand that information released may include information indicating the presence of communicable disease, including but not limited to hepatitis, syphilis, gonorrhea, and HIV or AIDS.

INITIALS

DATE

EXPIRATION AND REVOCATION

I understand that I may revoke this authorization in writing at any time, except to the extent that the person or organization named above has already acted in reliance on it.

THIS AUTHORIZATION EXPIRES ON

OR UPON THIS EVENT

If no date or event is entered, this authorization expires one year from the date signed.

I understand that Dr. Ireland will not condition my treatment on whether I give authorization for the requested disclosure, and that I need not sign this authorization to ensure treatment, payment, enrollment in a health plan, or eligibility for benefits.

Federal and state laws protect information disclosed under this authorization. I understand that if the authorized recipient is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and would no longer be protected.

I have read and understand the terms of this authorization, I have had the opportunity to ask questions, and I have been informed of my right to a copy of it after signing.

CLIENT SIGNATURE

DATE

GUARDIAN OR REPRESENTATIVE SIGNATURE

DATE

PRINTED NAME

RELATIONSHIP AND LEGAL AUTHORITY