



# The Emily Program

Personalized treatment for eating disorders.

1700 Westlake Ave N, Suite 650, Seattle, WA 98109, P: 206.283.2220 F: 206.283.2223

## AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

### Client Information

Name (printed): \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Other Names Used: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Parent/Guardian/Legal Representative Name (minors only): \_\_\_\_\_

**Health Care Provider, Person, Agency or Emergency Contact Information:** To help us ensure high quality treatment and coordination of care, please provide the name and contact information of the provider, person, agency or emergency contact (outside of The Emily Program) with whom The Emily Program will exchange the information indicated below. *Example: your primary care provider*

\_\_\_\_\_  
Clinic/Physician/Provider, Person, Agency or Emergency Contact Name Relationship to Client (e.g. PCP, Mother, etc) Phone

\_\_\_\_\_  
Clinic/Physician/Provider, Person, Agency or Emergency Contact Street Address, City, State, Zip Fax

I authorize The Emily Program to **RECEIVE** the following types of information from the provider, person or agency listed above.

I authorize The Emily Program to **SEND** the following types of information to the provider, person or agency listed above.

Please indicate the *type of information* to be released (check all that apply):

Please indicate the *purpose* of the release of information (check all that apply):

- Case/Progress Notes
- Psychological Testing Results
- General Program Intake
- Discharge Summaries
- Entire Record
- Ongoing Verbal Communication
- Other (please specify) \_\_\_\_\_

- Continuity/Coordination of Care
- Discharge and Continuation of Care
- Client Request
- Insurance
- Litigation/Legal Purposes
- Other (please specify) \_\_\_\_\_

In addition, I authorize The Emily Program to disclose my protected health information to this individual as my Emergency Contact in situations in which The Emily Program perceives a threat to my health, safety or well-being.

In addition, I authorize that the disclosure may include information on the following:

- AIDS or HIV Infection       Drug or Alcohol Abuse       Genetic Testing

**Statement of Authorization:** I understand that I may revoke this consent at any time by providing written notice to The Emily Program at the address noted in the Notice of Privacy Practices, and that after one year this consent automatically expires; provided, however, that this consent shall automatically expire after ninety days if this consent authorizes the disclosure of personal health information to a financial institution or my employer for purposes other than payment. I have been informed what information will be released, its purpose and who will receive the information and I may inspect or copy the protected health information to be used or disclosed under this authorization. I understand that personal health information, once disclosed, might be re-disclosed and is no longer protected by federal privacy regulations. I also understand that I may refuse to sign this authorization. The Emily Program will not condition treatment, payment, enrollment or eligibility for services based on whether I sign this authorization. **BY SIGNING BELOW, I ACKNOWLEDGE THAT I HAVE READ AND THAT I UNDERSTAND THIS AUTHORIZATION FORM.**

\_\_\_\_\_  
Client Signature (required if client is 13 years or older) Parent/Guardian/Representative Signature Date

**Legal Representative** (required for clients under the age of 18 years): I am legally authorized to represent the client listed above and I understand that I may be asked to provide documentation to demonstrate this legal authority.

\_\_\_\_\_  
Parent/Guardian/Representative Signature Relationship to Client/Legal Authority Date

**Declination of Release:** I have not filled out the information above for the following reason:

- I do not have a primary care physician or other provider outside of The Emily Program.
- While I do have a primary care physician or other provider, I am choosing to not authorize the release.

\_\_\_\_\_  
Client Signature Parent/Guardian Signature Date