Comprehensive Outpatient Program for Eating Disorders (COPE™)

6100 Lake Forrest Dr., Suite 450, Atlanta, GA 30328

Phone: 404-343-4162 Fax: 404-549-9316

Consent and Authorization for Release of Information

If there are other parties that may assist in your therapy, and you believe it would be helpful for your therapist, dietician, psychiatrist and/or group leader to contact them regarding your treatment, please read and sign this document.

The following is an authorization for the stated parties to consult with one another (bi-directionally) regarding your treatment process. Information shared is for the sole purpose of facilitating maximum care to you as the client. Please provide the necessary information and your signature with today's date.
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I, ____ (client/legal guardian), hereby authorize the associates of AC4W involved in my care and named here ____ ____ and the following party or parties may discuss my diagnosis, treatment, information and records obtained during the course of psychotherapy Please list any person/entity you would like me to communicate with and list contact information (phone and/or email):

(1) Name____ Contact Info ________________________________

(2) Name____ Contact Info ________________________________

(3) Name____ Contact Info ________________________________

Please indicate your preference regarding the information to be shared:

_____ The parties stated above may discuss my medical and or mental health information without limitations.

_____ I would prefer to limit the information shared between the party stated above. The limitations are:

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The above named parties, therapist and person(s) or entity (entities) designated under (1) (2) and /or (3) agree to exchange information only between themselves (or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality.

Your signature below indicates that you understand that you have a right to enact and receive a copy of this authorization. Your signature also indicates that you are aware that any cancellation or modification of this authorization must be in writing, and you have a right to revoke this authorization anytime unless the therapist stated above has acted in reliance upon it. Additionally, if you decide to revoke this authorization, such a revocation must be made in writing and received by an associate of AC4W involved in your care and indicated by you above. NOTE: Treatment is not conditioned upon your signing this authorization, and you have the right to decline to sign this release form.

Signature of client or guardian:____ Date:______________________