Jeff Hopkins, M.D.

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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 me, your medical provider, to contact them regarding your treatment, please read carefully and complete this document.

The following is an authorization for the stated parties to consult with one another 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 sign and date below. Signing this bi-directional ROI gives permission to both parties to consult.

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I, _____ (client/legal guardian), hereby authorize Dr. Jeff Hopkins and/or Atlanta Center for Wellness staff and the following party or parties to discuss my treatment, information and records obtained during the course of treatment including but not limited to diagnosis. 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:

_____

_____

The above named parties, providers and person(s) or entity (entities) designated under (1) (2) and /or (3) agree to exchange information only between themselves (and/or their agents). Any disclosure of information extended beyond these parties is considered a breach of confidentiality. Please note, information will be shared confidentially through supervision and for billing purposes, however, only information necessary will be shared, and your confidentiality protection extends to any supervisors or professional agents affiliated with your provider.

Your signature below indicates that you understand that you have a right to 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 provider 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 Dr. Jeff Hopkins, M.D. NOTE: (Due to the delicate nature of an eating disorder dx, treatment may be conditioned upon your signing this authorization. If so, you have the right to decline to sign this release form and be referred to another provider).

Signature of client or guardian:_____ Date:_____