Mindfullness

EATING DISORDER RECOVERY

Consent to Release Health Information

I _____ hereby authorize _____

(Mindfullness staff) to release and exchange information pertaining to:

- ☐ My clinical record
- ☐ My son, daughter, or legal guardian's clinical record

Information will be released to the organization or professionals listed below:

Name: _____

Address: _____

Phone Number: _____

The purpose of this disclosure is to aid in the coordination and assessment of treatment planning. You can revoke consent at any time. If you do not choose to express your right of revocation, the consent form expires at the termination of your treatment contract with Mindfullness.

Client Signature: _____ Date of Signature:_____

Witness Signature: _____ Date of Signature:_____