Reasons Eating Disorder Center - BHC Alhambra Hospital
4619 Rosemead Blvd.
Rosemead, CA 91770
p: 626.286.1191
f: 626.270.4226

AUTHORIZATION FOR EXCHANGE OF INFORMATION

I hereby authorize Reasons Eating Disorder Center at BHC Alhambra Hospital

☐ to release the following information to: and/or ☐ to obtain the following information from:

_____ _____
(Name of person or facility) *(Phone)*

_____
(Street Address, City, State, Zip Code)

INFORMATION TO BE RELEASED:

☐ Discharge Summary	☐ Psychiatric Assessments and Notes	☐ Progress Notes
☐ Treatment Plans and Summaries	☐ Psychosocial Assessments	☐ Testing Results
☐ History and Physical Exams	☐ Laboratory Reports/EKG's	☐ Nursing Notes
☐ Nutrition Evaluation and Notes	☐ Vital signs/weights	

☐ Other: _____

THE PURPOSE OF THIS RELEASE IS (check one or more):

☐ At the request of the patient/patient representative

☐ Other (state reason) At the request of Reasons of Reasons Eating Disorder Center for purpose of coordination of care.

_____

NOTICE

Reasons Eating Disorder Center at BHC Alhambra Hospital is required by law to keep your health information confidential. If you have authorized the disclosure of your health information to someone who is not legally required to keep it confidential, it may no longer be protected by state or federal confidentiality laws.

MY RIGHTS

- I understand this authorization is voluntary.
- I may revoke this authorization at any time, provided that I do so in writing and the revocation will take effect when Reasons receives it, except to the extent that Reasons or others have already relied on it.
- I am entitled to receive a copy of this Authorization.

EXPIRATION OF AUTHORIZATION

Unless otherwise revoked, this authorization expires _____*(date)*. If no date is indicated, this Authorization will expire 12 months after the date of signing this form.

SIGNATURE

_____ _____
(Signature of Patient or Patient's Legal Representative) *(Date)*

_____ _____ AM/PM
(Printed Name) *(Time)*

_____
(Witness Signature)