MEDICAL CENTER FOR EATING DISORDERS
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701 N. Post Oak Road, Suite 220
Houston, TX 77024
Phone: (713)956-4083 | Fax: (832) 916-2033

Medical Release of Information

Patient Name: _____ DOB: _____

Address: _____ City, State, Zip: _____

Phone Number: _____ Email: _____

Provider Information:

I authorize the Medical Center for Eating Disorders to (check one or both of the following):

☐ obtain information from: ☐ release information to:

Name of Provider or Facility:_____

Address: _____ City, State, Zip:_____

Phone: _____ Fax: _____

Purpose of this Request: _____

_____

Specific Information Authorized (check one or more as appropriate):

☐ History & Physical
☐ Operative Reports
☐ Laboratory Reports
☐ Emergency Room Reports
☐ Diagnostic Reports (i.e., EKG, EEG, Sleep Study)
☐ Consultation Reports
☐ Radiology Reports
☐ Pathology Reports
☐ Other: _____

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- I may cancel this authorization at any time by submitting a written request to Medical Center for Eating Disorders, except where a disclosure has already been made in reliance on my prior authorization.
- Release of HIV-related information requires additional information.

Expiration of Authorization:

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

_____ _____
Patient/Guardian Signature Date

_____
Patient/Guardian Printed Name