OHIO UNIVERSITY
Division of Student Affairs

Counseling and Psychological Services
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office use only
Reviewed by:

Ohio University
Interdisciplinary Eating Disorder Support Team (EDST)
Authorization for Release of Confidential Information

I, _____, date of birth _____, OUPID # _____,

hereby authorize staff members of the Eating Disorder Support Team,

To ☒ release and obtain my protected health information to and from other professionals who are part of the EDST, including:

- Counseling and Psychological Services
- Designated Ohio University Athletic Trainers
- Designated Physicians at Campus Care
- WellWorks Nutrition Services

The following information:

☐ Verification of Attendance
☐ Assessment and Diagnosis
☐ Psychiatric Treatment
☐ Medication Information
☐ Summary of Treatment
☐ Other: _____

This Authorization includes release of records relating to:

☐ Diagnoses and/or treatment for alcohol and/or drug abuse
☐ AIDS/AIDS related complex (ARC) diagnoses and/or Treatment
☐ HIV test results
☐ Diagnosis and/or treatment of other communicable diseases

Indicate here specific instructions, if any, regarding dates of treatment or amount of information to be released or obtained:

_____

The purpose of disclosure is:

☐ Continuity of Care
☐ Assisting in Assessment
☐ Coordination of Services

☒ Other: The purpose of this document is to allow the EDST to coordinate my care and learn from the suggestions offered by team members.

This authorization shall remain in effect for: ☐ 90 days ☐ 180 days ☐ Other _____

- I understand that information may be exchanged verbally, via email or fax. I understand that team members are obligated to keep my information confidential. I understand that a list of EDST members is available upon request.

Phone Number to reach Client/Guardian/Personal Representative: _____

_____ _____
Printed Name of Client | Signature of Client

_____ _____
Printed Name of Guardian/Personal Representative (If Applicable) | Signature of Guardian/Personal Representative (If Applicable)

_____ _____
Today's Date | Witness Signature and Date

Revocation: This authorization is subject to written revocation at any time except to the extent the program or person who is to make the disclosure has already acted in reliance on it.

I hereby revoke consent _____ _____
Client Signature and Date | Witness Signature and Date