MONTE NIDO & affiliates

Monte Nido® clementine A MONTE NIDO AFFILIATE for adolescents Oliver-Pyatt CENTERS treatment programs for women and girls

Consent to Release Mental Health Information

I, _____**(client name - printed), hereby authorize Monte Nido & Affiliates (see list below) and the following party:**

Name: _____ Relation to Client: _____

Address: _____

E-Mail: _____

Phone: _____Fax: _____

and their respective agents, and/or employees, to disclose to and/or obtain from each other any and all information and/or records regarding my psychological and mental diagnosis and treatment and other pertinent information relative to my past, present, or future mental condition. I realize that the exchange and disclosure of information between each of such parties is for the purpose of assisting all involved in properly treating me and facilitating transition of care.

I understand that authorizing the disclosure of this mental health information is voluntary. I can refuse to sign this authorization. I may also request that only specific information is communicated. Furthermore, I understand that I may revoke this authorization at any time. If I revoke this authorization, I must do so in writing to the applicable parties named herein. I understand that the revocation will not apply to information that has already been released in response to this authorization. Additionally, I understand that treatment or payment cannot be conditioned on my signing this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal or state confidentiality rules.

This authorization expires two (2) years from the date signed. I have received a copy of the signed authorization.

Please select what records are being requested / disclosed:

❑ Presence in Treatment ❑ Any Portion of and/or Complete Record

❑ Information Necessary for the Processing/Payment of Billing ❑Other _____

_____ _____

Client Name (Printed) DATE OF BIRTH

_____ _____

Client Signature Date

_____ _____

Legal Guardian Signature (when applicable) Date

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Monte Nido | clementine — A MONTE NIDO AFFILIATE for adolescents | Oliver-Pyatt CENTERS — treatment programs for women and girls

Monte Nido and Affiliates

The above consent for release of information includes the facilities and programs listed below.

Monte Nido 514 Live Oak Circle Drive, Calabasas, CA 91302 (P) 818-222-9534 (F) 818-222-3818	Monte Nido Vista 28855 Lake Vista Dr. Agoura Hills, CA 91301 (P) 818-338-7890 (F) 818-338-7897
Eating Disorder Center of California 520 S. Sepulveda Blvd. Suite 208 Brentwood, CA 90049 (P) 310-472-3728 (F) 310-472-9960	RainRock 41496 McKenzie Hwy Springfield, OR 97478 (P) 541-896-9300 (F) 541-343-8152
Eating Disorder Center of Eugene 939 Willagilespie Rd. Eugene, OR 97401 (P) 541-896-9300 (F) 541-343-8152	Eating Disorder Center of Portland 5550 Macadam Ave. Suite 100 Portland, OR 97239 (P) 541-896-9300 (F) 971-202-4929
Monte Nido at Laurel Hill Inn 121 Mystic Street Medford, MA, 02155 (P) 781-391-8000 (F) 781-391-8008	Eating Disorder Center of Boston 419 Boylston St. Suite 502 Boston, MA 02116 (P) 857-233-9969 (F) 857-263-7388
Monte Nido New York at Irvington 100 S. Broadway Irvington, NY 10533 (P) 914-479-5860 (F) 914-479-5868	Eating Disorder Treatment of New York 111-117 W 72nd St. New York, NY 10023 (P) 646-833-7325 (F) 646-883-7322
Oliver Pyatt Centers 5830 SW 73 St Miami, FL 33143 (P) 305-663-1738	Clementine 5830 SW 73 St Miami, FL 33143 (P) 305.663.1738