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 automatically 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

List of Monte Nido Affiliates

If information is requested, please send to the location checked below

❑ Admissions / Administrative Office 23815 Stuart Ranch Rd. Suite 302 Malibu, CA 90265 (P) 310-457-9958 (F) 310-457-8442	❑ Community Counseling for Individuals & Families 23815 Stuart Ranch Rd. Suite 302 Malibu, CA 90265 (P) 310-457-9958 (F) 310-457-8442
❑ 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 Programs 23815 Stuart Ranch Rd. Suite 302 Malibu, CA 90265 (P) 310-457-9958 (F) 310-457-8442