The Counseling Center of Florence, LLC

PHONE: (843) 673-0054
FAX: (843) 667-1549
616 S. COIT ST.
FLORENCE, SC 29501

Patient Name: _____ Insurance ID: _____

AUTHORIZATION FOR DISCLOSURE OF MENTAL HEALTH TREATMENT INFORMATION

This form, when completed and signed by you, authorizes The Counseling Center of Florence, LLC or J.G. Martin Enterprises to **release and receive** protected health information with the person or people you designate.

Patient Information:

_____ Name

_____ Address

_____ Date of Birth

_____ City, State & Zip Code

_____ Parent/Guardian Name if Minor Child

_____ Phone Number

Authorization for Release. I hereby authorize the exchange of information between The Counseling Center of Florence, LLC or J.G. Martin Enterprises and:

_____
Name of Person or Organization & Relationship to Patient

_____
Address

_____
City, State and Zip Code

_____ Phone Number _____ Fax Number

Specific Authorization. I specifically authorize the release and/or exchange of the following Confidential Information (Please **initial** each you wish to authorize):

____ Records ____ Scheduling ____ Financial ____ Appointment/Attendance Confirmation

____ All (Records, Financial, Scheduling, Appointment/Attendance Other _____
(Please Specify)

Re-disclosure. This release does **NOT** authorize re-disclosure of confidential information beyond the limits of this consent except in the case of court ordered evaluations where the information may be disclosed to the court. The recipient of this information is **PROHIBITED** from using the information other than the stated purpose, and from disclosing to any other party without further authorization.

Validity. I understand that this authorization will automatically expire **one year** from the date of signature. I may revoke this authorization by sending a written notice to the person or entity authorized to make the disclosure described above.

I authorize the release of information as indicated above.

_____ _____
Signature of Patient or Parent/Guardian if Minor Child (Date)

_____ _____
Staff Signature (Date)

If authorization is signed by a personal representative of the patient, a description of such representative's authority to act for the patient must be provided. (Parent of minor child, legal guardian, etc.)