The Saluda Counseling Center

REQUEST FOR AND AUTHORIZATION TO RELEASE INFORMATION

Please fill out this form completely, including addresses and contact phone numbers for both you and the person(s) or facility you are requesting information be released to/from. If this form is incomplete, we may not be able to comply with your request

Patient Name:_____ DOB:_____ SSN:_____

Patient Address:_____ Phone:_____

I hereby request and authorize: The Saluda Counseling Center
2400 West Main Street Rock Hill, SC 29732
Phone: 803-327-6103 Fax: 803-328-5443

To release the following information to:

Provider/Practice: _____

Address: _____

_____

Phone/Fax: _____

Items to be released (*Check all that apply*):

☐ Entire Medical Record ☐ Diagnosis ☐ Medication Orders ☐ Clinical History and Evaluation

☐ History & Physical ☐ Summary of Treatment ☐ Mental Status Exam ☐ Other:_____

I may withdraw this consent at any time by written notification. Without written notice to withdraw this consent, it expires one year from the date of origination or upon release of the requested information if limits were set by the patient filling out this form. I am aware that my medical records may or may not reflect information concerning psychological or psychiatric impairments, drug abuse, and/or alcoholism, and/or information regarding tests or the infection of HIV and other infectious diseases. I understand this is all part of my medical history and that it may be included in my medical records.

_____ _____

Patient/Authorized Person Signature Date

_____ _____

Authorized Person's Relationship to Patient (*if applicable*) Expiration Date

_____ _____

Witness Signature Date

Note: The execution of this form does not authorize the release of information other than that specifically described. The information requested on this form is protected by State and Federal Laws and will authorize release of the information specified.