Coastal Samaritan Counseling Center

Instilling hope and healing

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CONSENT AND AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name_____

Address_____

DOB_____SSN_____

☐ I authorize the disclosure of my medical records from The Coastal Samaritan Counseling Center to the person/organization listed below:

☐ I authorize the disclosure of my medical records from the person/organization listed below to The Coastal Samaritan Counseling Center:

Name_____Phone_____

Address_____Fax_____

_____Relation to Client_____

Portion of Medical Record to be released:

☐ Entire Medical Record
☐ Clinical History and Evaluation
☐ Psychiatric History and Mental Status
☐ Progress Notes
☐ Physician's Medication Orders
☐ Admission/Discharge Dates
☐ Diagnoses
☐ Discharge Summary
☐ History and Physical
☐ Consultant's Notes
☐ Other (Please List) _____

I understand that all client information is confidential and my records cannot be disclosed without my written consent unless otherwise provide for by law. I acknowledge that the information being released was fully explained to me and that this consent is given freely. I also understand that I may withdraw my consent at any time by written notification to the facility.

_____ _____
X Client Signature Date

_____ _____
Authorized Person (if client is a minor or unable to sign) Date

_____ _____
X Witness to Signature Date