Coastal Samaritan Counseling Center
Instilling hope and healing

1297 Professional Drive, Suite 101, Myrtle Beach, SC 29577
Phone: (843) 448-4820/Fax: (843) 448-9875
E-mail: csccinfo@coastalsamaritan.org
Website: www.coastalsamaritan.org

CONSENT AND AUTHORIZATION TO RELEASE CONFIDENTIAL INFORMATION

Client's Name: _____ DOB: _____

Address: _____

SSN: _____ Provider's Name: _____

☐ I authorize the disclosure of my medical records from The Coastal Samaritan Counseling Center to the entity listed below.

☐ I authorize the disclosure of my medical records from the entity listed below to The Coastal Samaritan Counseling Center.

☐ I authorize the disclosure of my medical records from The Coastal Samaritan Counseling Center to myself, the client. (Same as Client Name Listed Above)

☐ I revoke my authorization to disclose my medical records from The Coastal Samaritan Counseling Center.

RELEASE CONFIDENTIAL INFORMATION TO:

Name: _____

Address: _____

Phone: _____ Fax: _____

E-mail: _____ Relation to Client: _____

PORTION OF MEDICAL RECORD TO BE RELEASED:

◯Entire Medical Record ◯Progress Notes ◯Summary Letter with dates and diagnosis

◯Discharge Summary ◯Summary Letter with dates

I understand that all client information is confidential and my record cannot be disclosed without my written consent unless otherwise provide for by law. I understand that CSCC will only release records that were created and maintained by our counselors and center. We will not release records received from other clinics or providers. I acknowledge that the information being release 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 Coastal Samaritan Counseling Center.

Client Signature/Authorized Person _____ Date: _____

Witness Signature _____ Date: _____