Coastal Samaritan Counseling Center
Instilling hope and healing

Accredited by the Solithen Institue
United Way Community Partner

CLIENT CONSENT FOR COORDINATION OF CARE

Client Name: _____ **Date of Birth:**_____

I, the undersigned, hereby authorize the release and exchange of information between:

Mental Health Provider

Name: **Michelle Estep, MA, LPC**

Address: **1297 Professional Drive Suite 101 Myrtle Beach, SC 29577**

Phone: **843-448-4820 Fax: 843-448-9875**

And the Following Physician/Healthcare Provider:

Name: _____

Practice Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Purpose of Disclosure (check all that apply):

☐ Coordination of care
☐ Medication management
☐ Continuity of treatment
☐ Diagnostic clarification
☐ Referral
☐ Other: _____

Information to Be Shared (check all that apply):

☐ Diagnosis
☐ Treatment plan
☐ Progress notes
☐ Medical history
☐ Medications
☐ Discharge summary
☐ Other: _____

Client Consent

I understand that this information will be used solely for the purposes listed above. I understand that I may revoke this consent at any time in writing, except to the extent that action has already been taken in reliance upon it. This consent will expire one year from the date of signing unless otherwise specified below.

Expiration Date of Consent (if different from 1 year): _____

Client/Guardian Signature: _____

Date: _____

Printed Name of Client/Guardian: _____

Relationship to Client (if applicable): _____

Witness Signature: _____

Date: _____

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CLIENT CONSENT FOR COORDINATION OF CARE

Client Name: _____ **Date of Birth:**_____

I, the undersigned, hereby authorize the release and exchange of information between:

Mental Health Provider

Name: **Stacy Fraser, LPC**

Address: **1297 Professional Drive Suite 101 Myrtle Beach, SC 29577**

Phone: **843-448-4820 Fax: 843-448-9875**

And the Following Physician/Healthcare Provider:

Name: _____

Practice Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Purpose of Disclosure (check all that apply):

☐ Coordination of care
☐ Medication management
☐ Continuity of treatment
☐ Diagnostic clarification
☐ Referral
☐ Other: _____

Information to Be Shared (check all that apply):

☐ Diagnosis
☐ Treatment plan
☐ Progress notes
☐ Medical history
☐ Medications
☐ Discharge summary
☐ Other: _____

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CLIENT CONSENT FOR COORDINATION OF CARE

Client Name: _____ **Date of Birth:**_____

I, the undersigned, hereby authorize the release and exchange of information between:

Mental Health Provider

Name: **C. Jane Osment, MAR, M.Div., MFT, LPC**

Address: **1297 Professional Drive Suite 101 Myrtle Beach, SC 29577**

Phone: **843-448-4820 Fax: 843-448-9875**

And the Following Physician/Healthcare Provider:

Name: _____

Practice Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Purpose of Disclosure (check all that apply):

☐ Coordination of care
☐ Medication management
☐ Continuity of treatment
☐ Diagnostic clarification
☐ Referral
☐ Other: _____

Information to Be Shared (check all that apply):

☐ Diagnosis
☐ Treatment plan
☐ Progress notes
☐ Medical history
☐ Medications
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Relationship to Client (if applicable): _____

Witness Signature: _____

Date: _____

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CLIENT CONSENT FOR COORDINATION OF CARE

Client Name: _____ **Date of Birth:**_____

I, the undersigned, hereby authorize the release and exchange of information between:

Mental Health Provider

Name: **Bethany Naus, MA, LPC-A**

Address: **1297 Professional Drive Suite 101 Myrtle Beach, SC 29577**

Phone: **843-448-4820 Fax: 843-448-9875**

And the Following Physician/Healthcare Provider:

Name: _____

Practice Name: _____

Address: _____

City, State, ZIP: _____

Phone: _____ Fax: _____

Purpose of Disclosure (check all that apply):

☐ Coordination of care
☐ Medication management
☐ Continuity of treatment
☐ Diagnostic clarification
☐ Referral
☐ Other: _____

Information to Be Shared (check all that apply):

☐ Diagnosis
☐ Treatment plan
☐ Progress notes
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Date: _____