Coastal Haven Counseling, LLC
220 Ronnie Ct Suite 2 Myrtle Beach, SC 29579
3100 Dick Pond Rd Ste D Myrtle Beach, SC 29588
3723-C Forestbrook Rd Myrtle Beach, SC 29588
(843) 945-0346

Client Name:_____ Date:_____

Client Emergency Contact Name: (PRINT)_____
Emergency Contact Relationship to Client:_____
Emergency Contact Phone Number: _____
I authorize Coastal Haven Counseling, LLC., my therapist and/or the Clinical Director to use the above information in the event of an emergency while I am a current client.

*****Coordination of Care - Would you like us to send records to your Doctor's office? INITIAL Yes or No***
_____Yes, If YES, please complete the next section in full.
_____ No

Authorization to Use and Disclose Specific Protected Health Information

By signing this Authorization, I (client) _____, hereby direct the use or disclosure by *Coastal Haven Counseling, LLC and Associates* of certain medical and/or mental health information pertaining to my health, my health care, or myself.

This Authorization concerns the following medical/mental health information about myself:

_____ Treatment Plan _____ Progress Summaries _____ Case Notes
_____Check here for all mental health information to release
Other:_____

This information may be used or disclosed by *Coastal Haven Counseling LLC and Associates* and may be disclosed to/received from:

Name doctor's office/doctor name, address and/or phone number or pertaining party below:

_____

_____

[LIST NAME OR SPECIFIC IDENTIFICATION OF THE PERSON(S) OR CLASS OF PERSONS TO WHOM YOU MAY MAKE THE REQUESTED USE/DISCLOSURE]

I understand that I have the right to revoke this Authorization at any time except to the extent that *Coastal Haven Counseling, LLC and Associates* has already acted in reliance on the Authorization. To revoke this Authorization, I understand that I must do so by written request. I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and no longer subject to privacy protections provided by law. I understand that my written authorization is not required for *Coastal Haven Counseling LLC and Associates* to use my protected health information for treatment, payment and health care operations. I understand that I have the right to inspect and copy the information that is to be used or disclosed as part of this Authorization. The Authorization is being requested by *Coastal Haven Counseling LLC and Associates* for the following purpose(s): Mental Health Therapy & Coordination of Care

I acknowledge that I have read the provisions in the Authorization and that I have the right to refuse to sign this Authorization. I understand and agree to the terms as stated in this form. This authorization expires on one year from date signed, unless otherwise noted:

Print Name: _____ Date: _____

Signature: _____
****If client is 18 or older, client must sign document.**