Coastal Haven Counseling, LLC
220 Ronnie Ct Ste 2 Myrtle Beach, SC 29579
1506 Azalea Dr Suite 603 Surfside Beach, SC 29575
9708 N Kings Hwy Myrtle Beach, SC 29572
(843) 945-0346

Authorization to Use and Disclose Specific Protected Health Information

By signing this Authorization, I **(client/guardian)** _____, 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, for myself or child. ***If this release of records is for a minor child, I confirm that I am the legal guardian of this child by signing below.***

Name of Client(s):_____

This Authorization concerns the following medical/mental health information to release:

_____ **Check here to release for all mental health information**

Or specify which information specifically to release:

_____ Treatment Plan

_____ Progress Summaries

_____ Other _____

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

Please list name of doctor's office/doctor name, DSS of Horry County, Horry County Schools or pertaining party below with address and/or fax number:

_____

_____

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I understand that I have a 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 this Authorization. To revoke this Authorization, I understand that I must do so by written request which can be emailed to coastalhavencounseling@gmail.com or faxed to (843) 432-3091. 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, &/or 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 &/or by the request of the client or guardian.

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 (Client/Guardian) : _____ Date: _____

Signature: _____