220 Ronnie Ct Ste 2 Myrtle Beach, SC 29579
1506 Azalea Dr Suite 603 Surfside Beach, SC 29575
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): _____

Insurance Number: _____ This Authorization concerns the following medical/mental health information to release: **CHECK ONLY ONE BELOW:**

_____ **I DO NOT WANT ANY RECORDS RELEASED AT THIS TIME** ***OR***

_____ **CHECK HERE TO RELEASE ALL MENTAL HEALTH INFORMATION AND RECORDS.**

Or specify which information specifically to release:

_____ Treatment Plans _____ Progress Summaries ____Billing Statements _____ 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:

_____

_____

_____

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: _____