

**Authorization to Use and Disclose Specific Protected Health Information**  
**Coastal Haven Counseling, LLC**

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

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. Information may be transmitted via fax, electronic health record exchange, or secure email.

NAME OF CLIENT: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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.** All mental health records including assessments, diagnoses, treatment plans, progress notes, discharge summaries, including substance use disorder information and billing information unless otherwise specified below.

Or specify which information specifically to release:  Treatment Plans  Progress Summaries  
 Billing Statements  Substance Use (SUD) Info  Other \_\_\_\_\_

This information may be disclosed to the following person(s), organization(s), or general designation of recipient. Please list name of treating healthcare providers, insurance companies, care coordination partners, schools or government agencies, etc with secure email address and/or fax number:

\_\_\_\_\_  
\_\_\_\_\_

I understand that I may revoke this Authorization at any time by submitting a written request to Coastal Haven Counseling, LLC via email at admin@coastalhavencounseling.com or fax at (843) 432-3091, except to the extent action has already been taken in reliance on this Authorization. I understand that information disclosed under this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state privacy laws. I understand that my authorization is not required for Coastal Haven Counseling, LLC to use or disclose my protected health information for treatment, payment, or health care operations, and that I have the right to inspect or obtain a copy of the information to be disclosed. This Authorization is requested for the purpose of mental health treatment, coordination of care, and/or at the request of the client or guardian. I understand that signing this Authorization is voluntary and that Coastal Haven Counseling, LLC will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this Authorization. This Authorization expires one year from the date signed or upon completion of the stated purpose unless revoked earlier in writing. This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). These rules prohibit further disclosure of this information unless expressly permitted by the written consent of the individual whose information is being disclosed or as otherwise permitted by 42 CFR Part 2.

Print Name (Client/Guardian) : \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_ Insurance #: \_\_\_\_\_