225 Adley Way – Greenville, SC 29607
(864) 987-9747 – fax (864) 987-9770

SHERBONDY'S
PSYCHIATRIC SERVICES

CONSENT TO RELEASE / RECEIVE CONFIDENTIAL INFORMATION

I, _____ authorize _____ at the above address to:
Patient Name (Print) Physician Name (Print)

(Check all that apply)

COORDNATION OF CARE

May we contact your physician: □ ***YES*** □ ***NO*** □ ***I DO NOT HAVE A PHYSICIAN***

Primary Care Physician: _____ Phone: _____

Address: _____ City: _____State _____ Zip: _____

Therapist Name: _____ Phone: _____

Address: _____ City _____ State _____ Zip: _____

□ ***Receive my medical history information from the following physicians:***

Name & Address: _____Ph:_____Fax: _____

_____

Name & Address: _____Ph:_____Fax: _____

_____

□ ***Release my treatment information/records to the following Person(s):***

Name: _____ Relationship: _____

Name: _____ Relationship: _____

□ ***Release my treatment information to the health insurance company listed below for billing purposes:***

Insurance Provider (Name, Address) _____

_____

This information is for the following purposes (any other use is prohibited) _____

_____

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken in reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and / or treatment for alcohol and / or drug dependency. These records may also contain confidential information about communicable diseases including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information / records under 42 CFR Part 2, and I further acknowledge that understand those rights.

_____ _____ _____
Signature of Patient (or Patient's Legal Representative) **Patient Name (PRINT)** **Date**

_____ _____ _____
Witness Signature **Witness Name (PRINT)** **Date**