



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

CONSENT TO RELEASE / RECEIVE CONFIDENTIAL INFORMATION

I, _____ authorize Sherbondy's Psychiatric Solutions at the above address to:
Patient Name (Print) Physician Name (Print)

(Check all that apply)

COORDINATION OF CARE

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

Primary Care physician: _____ PH: _____
Address: _____ City: _____ State _____ Zip: _____

Therapist Name: _____ PH: _____
Address: _____ City _____ State _____ Zip: _____

Receive my medical history information from the following physicians:

Name & Address: _____ PH# _____ FX# _____

Name & Address: _____ PH# _____ FX# _____

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