POST TRAUMA RESOURCES, LLC
1709 LAUREL STREET, COLUMBIA, SC 29201
PHONE: (803) 765-0700 FAX: (803) 765-1607

AUTHORIZATION for RELEASE OF CONFIDENTIAL HEALTH INFORMATION

PATIENT INFORMATION:

Patient's Last Name _________________________ First Name __________________________ MI _________

Date of Birth _______________________________ Telephone Number _______________________________

INFORMATION RELEASED TO AND/OR RECEIVED FROM:

Name of Person, Agency or Program ____

Address ____

City ____ State ___________ ZIP ________________________

Telephone ______________________________________ Fax ______________________________________

PURPOSE FOR DISCLOSURE:

	Referral for services from provider		Insurance claim
	Coordination of services between providers		Personal use
	Legal / attorney inquiry		Other: ______________________________

I understand that the information in my mental health record may include information related to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), if any. It may also include information about treatment for alcohol and drug abuse.

I understand that I can revoke this authorization at any time by giving written notice of revocation to Post Trauma Resources. I understand that revoking this authorization will not affect disclosures made or actions taken before the revocation is received. I understand that this authorization is valid for six months from the date signed, unless I revoke this authorization or unless an earlier date is specified here: ________________.

I understand that Post Trauma Resources cannot control how the authorized person or organization uses or shares the information. I understand that once the information is received by the authorized person or organization, it may be subject to redisclosure and may no longer be protected by federal privacy laws.

SIGNATURE

I have reviewed the above information and hereby authorize the above use and disclosure:

____ Date ______________________________

Printed name ____

Relationship to patient: [ ] Self [ ] Parent / Guardian (if child) [ ] Other __________________________

FOR OFFICE USE ONLY

I have reviewed this request and have authorized the release of the requested mental health records:

Therapist ____ Date ______________________________