Trinity Whole Health
121 Lawson St. Ste D
Florence, SC 29501
V:843-806-2247 F:864-405-0675

# AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Including Medical and Mental Health Records

Patient's Name:_____ Date of Birth: _____

Previous Name(s): _____Social Security #: _____

I request and authorize to release healthcare information of the patient named above to:

Name: **Aran Ingham FNP - Trinity Whole Health**

Address: **121 Lawson St. Ste D Florence, SC 29501**

Phone#: **843-806-2247** Medical Record Fax#: **864-692-4876**

Federal Regulation, 42 CFR Part 2, requires a description of the amount, the kind of information that is to be disclosed and the purpose for this disclosure.

This request and authorization applies to: □ All records available □ All correspondence

Or the specific records indicated here:

□ Psychiatric Evaluation □ Psychological Testing □ Diagnosis □ School Evaluation
□ Summary of Treatment □ History □ Medications
□ Legal issues/concerns □ Psychological Assessment □ Performance
□ Other (specify)_____

and is to be released for the purpose of: □ Continuity of care □ Other: (specify) _____.

By checking the boxes below, I specifically authorize the voluntary release of the following types of medical records, if such records exist.

□ Yes □ No I authorize the release of my HIV/AIDS records, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

□ Yes □ No I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

This consent to release is valid for one year, or until otherwise specified, and thereafter is invalid. Specify date, event, or condition on which permission will expire:
_____ I understand that at any time between the time of signing and the expiration date listed above I have the right to revoke this consent at any time to the extent that information has already been released based on this authorization.

Patient Signature:_____ Date Signed:_____

Relationship to patient: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.