Consent to Release Information

This form is to be completed if you consent for Hope Performance Systems, LLC to release specific information to or receive information from an identified third party.

Client Information

_____
First Name *Middle Name* *Last Name*

_____
Client Address *City* *State* *Zip Code*

_____ _____ _____
Client Phone Number *Client Social Security Number* *Client Date of Birth*

Medical Records Released From/To:

I hereby request and authorize: Hope Performance Systems, LLC
262 Red Cedar Street, Unit 4
Bluffton, SC 29910
(p)843-547-0200 (f) 843-706-2024

to release and/or receive specified written or verbal information to or from:

Agency: _____
Address: _____
City/State/Zip: _____
Phone: _____ Fax: _____
Attention: _____

Information to be Released (*check all that apply)*

- ☐ Intake/Admission History
- ☐ Discharge Summary/Transfer Summary
- ☐ Evaluations / Assessments
- ☐ Treatment Plan/Service Plans
- ☐ Financial Records Related to treatment / services from _____(date) to _____ (date).
- ☐ Listing of Dates of Treatment
- ☐ Progress Notes/Treatment Notes
- ☐ Fitness for Duty (letter for employer)
- ☐ Other: _____

Purpose of Release

- ☐ Coordination of Services between agencies
- ☐ On going treatment/services
- ☐ Legal
- ☐ Other: _____

Authorization & Acknowledgement

By Signing below, I acknowledge that I have read and understand the following:

1. This consent is subject to revocation at any time, except to the extent that action has been taken in reliance on the client's consent;
2. The consent will expire on _____. If no date is indicated or client has not revoked consent, the client's consent to release information will **expire ninety days (90)** after signature date.

_____ _____
Signature of Patient (or Guarantor, if applicable) Date

_____ _____
Signature of Witness (Agency Staff if applicable) Date