M. Smith Counseling Services, LLC
800 Columbiana Dr. Suite 120 Irmo SC 29063
Phone: (803)931-3331 Fax: (803)931-3536

Authorization to Exchange Information

I, _____ (hereinafter "Client") hereby authorize ***M. Smith Counseling Services, LLC*** ("Provider") to disclose/exchange mental health treatment information and records obtained during my psychotherapy treatment, including, but not limited to therapist's diagnosis of me, to the following individuals/entities:

Name	Relationship to Client	Address	Phone:	Fax:

I understand that I have a right to receive a copy of this authorization. I understand that any cancellation or modification of this authorization must be in writing. I understand that I have the right to revoke this authorization at any time unless Provider has taken action in reliance upon it. I also understand that such revocation must be in writing and received by Provider to be effective.

The specific uses and limitations of the types of health information to be released are as follows: (Check all that apply)

☐ Treatment Coordination ☐ Treatment Planning ☐ Other: _____

Such disclosures shall be limited to the following specific types of information:

☐ Psychological diagnosis ☐ Dates of Treatment ☐ Treatment Summary
☐ Initial Treatment Plan ☐ Full Treatment Record ☐ Other: _____

Provider shall not condition treatment upon Client signing this authorization and Client has the right to refuse to sign this form. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule, although applicable South Carolina law may protect such information.

_____ _____
Client/Authorized Representative Signature Today's Date

_____ _____
Printed Name Relationship to Client

Signature to Revoke consent: _____ Date: _____