CW Counseling & Consulting, LLC
Dr. Carol Wright, Ed.D., LISW-CP-S
2400 Second Loop Road
Florence, South Carolina 29501
Phone: (843) 667-1905

AUTHORIZATION FOR RELEASE OF INFORMATION (ROI)

Patient Information: Patient Name: _____
Date of Birth: _____

Authorization
I authorize **CW Counseling & Consulting, LLC** to:
☐ Release Information
☐ Obtain Information
☐ Exchange Information
with the following person/organization:

1. **Name/Organization:** _____
   Phone/Fax: _____
   Address: _____

2. **Name/Organization:** _____
   Phone/Fax: _____
   Address: _____

Purpose of Disclosure
☐ Continuity of Care
☐ Coordination of Services
☐ Insurance/Billing
☐ Legal/Court-Related
☐ School/IEP
☐ Other: _____

Information to be Released (Check all that apply)

☐ Assessment/Evaluation
☐ Diagnosis
☐ Treatment Plan
☐ Progress Notes (excluding psychotherapy notes)
☐ Attendance/Appointment Records
☐ Billing Information
☐ Discharge Summary
☐ Other: _____

Sensitive Information (Initial if applicable) I understand that the following information requires specific authorization:

- Mental health records
- Substance use treatment
- HIV/AIDS-related information

Initials: _____

Expiration of Authorization: This authorization will expire:

☐ On this date: _____
☐ Upon completion of treatment
☐ One year from date of signature

Right to Revoke: I understand that:

- I may revoke this authorization at any time in writing
- Revocation does not apply to information already released
- Treatment is not conditioned on signing this authorization

Redisclosure Notice: I understand that once information is disclosed, it may no longer be protected under HIPAA and could be redisclosed by the receiving party.

Telehealth & Coordination Acknowledgment: I understand that information may be shared for coordination of care, including telehealth services, when clinically necessary and authorized.

Signature: _____ Date: _____

I acknowledge that I have read and understand this authorization.

Patient/Guardian Name (Print): _____

Signature: _____ Date**: _____**

Relationship to Patient: _____

Witness/Provider

Signature: _____ Date**: _____**