SC Professional Services, LLC
d/b/a Hope Integrative Medicine
775 Saint James Avenue, Suite B
Goose Creek, SC 29445
Phone: 843.779.7718

Consent to Release / Receive Confidential Information

I, _____ authorize _____ to:
Patient Name (Please Print) Provider Name (Please Print)

MD/APRN check all that apply:

☐ Receive my medical history information from the following physician(s):
(Name, Address) _____
(Name, Address) _____

☐ Receive my treatment records from the following therapist:
(Name, Address) _____

☐ Release my treatment information/records to the following healthcare professional:
(Name, Address) _____

☐ Release my treatment information to the health insurance company listed below, for billing purposes:
(Name, Address) _____

The information is for the following purposes (any other use is prohibited): _____

I understand that I may withdraw this consent at any time, either verbally or in writing, except to the extent that action has been taken on reliance on it. This consent will last while I am being treated for opioid dependence by the physician specified above unless I withdraw my consent during treatment. This consent will expire 365 days after I complete my treatment, unless the physician specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or drug dependence. These records may also contain confidential information about communicable diseases, including HIV (AIDS) or related illness. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2), which prohibits the recipient of these records from making further disclosures to thirds parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

Patient Name (Please Print)	**Patient Signature**	**Date**
Parent/Guardian Name (if applicable) (Please Print)	**Parent/Guardian Signature**	**Date**
		Staff Initials

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