Strand Psychiatric Associates, P.A.

Murray Glenn Honick, M.D. — Child Adolescent & Adult Psychiatry

Renee Lamm, M.D. — Addiction Medicine & Psychiatry

Natali Amaradasa — FNP-BC, PMHNP-BC

Hannah Kloch — DNP, PMHNP-BC, FNP-C

Donna Jo Smolenski — MSN, APRN, PMHNP-BC

Cristina Gabriel — ANP-BC, PMHNP-BC

AUTHORIZATION TO RECEIVE AND RELEASE MEDICAL INFORMATION AND RECORDS

I understand that my records are governed by SC Code Am 17-22-70, as amended, the federal regulations governing confidentiality of alcohol and drug abuse records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for by law. I also understand that I may revoke this consent at any time except to the extent that action has been takin in reliance on it, and that in any event, this consent will expire automatically as follows: **Date:** _____

Patient Name: _____

Date of Birth: _____ **Phone:** _____

IMPORTANT: This authorization deals with the receipt, sharing, and/or disclosure of information from your medical records.

I authorize _____

Address: _____

City, St, Zip: _____

Phone: _____ Fax: _____

To disclose/ release/ exchange medical information/records with:

Strand Psychiatric Associates

3025 Newcastle Loop Myrtle Beach, SC 29588

Phone: 843-215-2400 Secure Fax: 843-215-2444

- o All Records
- o Laboratory
- o Discharge Summary
- o Other (describe specifically): _____
- o Records for services between the following dates: from _____ to _____.

The information may be obtained/disclosed for each of the following purposes:

- o For my health care
- o Other: _____

This authorization shall expire no later than: ____/____/____ or may not be valid for greater than one year from the date of the signature.

By signing below, I represent and warrant that I have the authority to sign this document and authorize that use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use of this protected health information.

_____ **Date:** _____

Signature of Patient (or patient's personal representative)

_____ **Date:** _____

Signature of Witness