iTrust Ψ Wellness Group
Psychiatric Prescribing Providers

Address: 117 Commons Way Greenville, SC 29611
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CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name (Please Print Clearly): _____ DOB: _____

I authorize any iTrust Wellness Group staff member who may be directly or indirectly involved in my care to disclose confidential information about me to the persons/agencies listed below. This confidential information includes, but is not limited to: my psychological/psychiatric history, my drug and alcohol use history, medical history, family history, legal and financial status, treatment history, results of diagnostic tests, urine tests, and clinical progress reports, current or planned treatment I may receive, all aspects of my treatment and clinical progress, and, all other information deemed important by the staff of iTrust Wellness Group to assist with my treatment and/or other personal or business matters including but not limited to comprehensive medical care, insurance reimbursement, legal action, regulatory action, marital conflict, child custody, etc.

I hereby authorize exchange of this information with the following persons, organizations/agencies:

_____ _____
Your psychiatrist, psychologist, or other therapist (specify name of person) Your Initials

_____ _____
Your primary care doctor or other medical doctors providing care (specify names) Your initials

_____ _____
Family members (specify name(s) of person(s)) Your Initials

_____ _____
Your attorney (specify name of person) Your Initials

_____ _____
Others (specify name(s) of person(s)) Your Initials

I understand and acknowledge this consent expires when I am no longer an active patient with the facility listed above or if revoked by me in writing and that I may do so at any time for any reason except to the extent that: 1) this information is deemed necessary to protect my personal safety and/or the safety of others who may be seriously affected by my behavior; 2) disclosure has already occurred; or, 3) any action that relies on this disclosure has already been taken and/or is in progress.

_____	_____	_____
(Printed Name of Patient, Guardian, Or Legal Representative)	(Signature of Patient, Guardian, Or Legal Representative)	(Date)