CAROLINA PSYCHIATRIC SERVICES, P.A.

160 Medical Circle, First Floor
West Columbia, SC 29169

Name ______________________________________ Date of Birth _________________

Purpose of this authorization is to coordinate patient care. I hereby authorize Carolina Psychiatric Services, P.A. to verbally release, discuss and receive information, to include, but not limited to, my diagnosis, treatment, medications, appointments, financial, billing and benefit information with the individuals listed below. This release is unrestricted unless noted below.

This consent will remain in effect until revoked in writing.

Name	Relationship

Note any restrictions:

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Patient (or Parent/authorized representative) Signature Date

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Witness Signature Date