Psychiatric Associates of Spartanburg, PA
943 N. Church Street
Spartanburg, SC 29303
864-585-2214

DISCLOSURE OF MEDICAL/MENTAL HEALTH/SUBSTANCE ABUSE INFORMATION

Disclosure of Medical Information: Your medical information and communication of that information is essential to your care. We prefer to speak directly with each patient but we understand that other individuals or family members may have knowledge of and be assisting in your care. Please list the individuals with whom we are authorized to discuss your care, therapy, medications, treatment plan, etc.

(NOTE: We can not discuss your care with others, including spouses or other family members living with you, unless they are listed below.)

Name of Person	Relationship to Patient
_____	_____
_____	_____
_____	_____

Signatures: I hereby authorize the use or disclosure of the personal health information as described above.

Patient Full Name (PRINT) _____ DOB _____

Patient/Personal Representative Signature: _____ Date: _____

PRINT Name of Personal Representative: _____

Relationship of Representative to Patient: _____

Note: This restriction applies only to care provided by Psychiatric Associates of Spartanburg, PA identified at the top of this form. Other providers involved in your treatment may require you to complete a separate request for restriction. Either you or Psychiatric Associates of Spartanburg, PA may terminate this restriction by completing the following.

The below signature is to be used if you would like to make the above information terminate on a certain date.

This agreement is terminated as of _____ Signature _____