PO BOX 1844, Columbia, SC 29116

Patient Authorization for Disclosure of Personal Health Information (PHI) for Psychological Testing Services

As a way to provide excellent care to our clients, MERGE Counseling & Coaching offers psychological and personality testing services, provided by clinical psychologist Dr. ____________________________. To receive a consultation simply supply the requestedcontact information, and grant your therapist permission to communicate about what testing services will be most helpful to you.

Client name:
____

Best phone number to be reached:
____

Best time of day to be reached:
____

Special requests:
____

By signing, I authorize **MERGE Counseling & Coaching, LLC** to disclose protected health information (PHI) about me to Dr. ______________________________________ and administration of _______________________________ Associates, for the purposes of helping me arrange an appointment for psychological testing services. I understand that discussion may involve aspects of my counseling treatment.

I have the right to refuse to sign this authorization, and I maintain the right to retract this authorization at any time.

Signed by:____ ______________
Signature of Patient (or Legal Guardian) Date